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29 November 2008

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Clamelle

Azithromycin 500mg Tablets

actavis
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To register with the NPA, contact 01727 800 401.

Clamelle®
Azithromycin 500mg Tablets

Product Information
Name: Clamelle Chlamydia Test Kit: a NAAT-accredited test provided by Gordon Laboratory Group

Product Information
Name: Clamelle Azithromycin 500 mg Tablets **Active ingredient:** Azithromycin 500 mg. **Indication:** Treatment of confirmed asymptomatic *Chlamydia trachomatis* genital infection in individuals aged 16 years and over and the epidemiological treatment of their sexual partners. **Dosage:** A single 1 g dose. Children: Do not give to children under 16. **Contraindications:** Hypersensitivity to azithromycin, macrolide antibiotics or excipients. Symptomatic infection. Symptoms suggestive of other STIs. Children under 16. Renal or hepatic impairment. Cardiac disease. Patients taking cidosporin, digoxin, ergotamine, terfenadine, theophylline, disopyramide, rifabutin, coumarin anticoagulants. Pregnancy and breast feeding. **Precautions:** To reduce risk of vomiting take dose before bed and at least 2 hrs after food or drink. If taking oral contraceptive and vomiting or diarrhoea occur, refer to contraceptive instructions for measures to reduce risk of contraceptive failure. **Interactions:** Antacids: Take azithromycin at least 1 hr before or 2 hrs after the antacids. See contraindications. **Side effects:** Infections: candidiasis. Blood: neutropenia, thrombocytopenia. Psychiatric: aggressiveness, restlessness, anxiety, nervousness. Nervous: dizziness, vertigo, convulsions, headache, somnolence, taste perversions, syncope, parasthesia, hyperactivity, asthenia, insomnia. Ear: hearing impairment including hearing loss, deafness and tinnitus. Cardiac: palpitations and arrythmias. QT prolongation and torsades de pointes. Vascular: hypotension. Gastrointestinal: nausea, vomiting, diarrhoea, abdominal discomfort, loose stools, flatulence, digestive disorders, anorexia, dyspepsia, constipation, tongue discolouration, pseudomembraneous colitis, pancreatitis. Hepatobiliary: abnormal liver function including hepatitis and cholestatic jaundice. Hepatic necrosis and failure. Skin: allergic reactions. Photosensitivity, oedema, urticaria, angioneurotic oedema, erythema multiforme, Stevens Johnson Syndrome, toxic epidermal necrolysis. Musculoskeletal: arthralgia. Renal: interstitial nephritis, acute renal failure. Reproductive: vaginitis. General: anaphylaxis, fatigue, malaise **Pregnancy and lactation:** Contraindicated. **RRP (excl VAT):** £17.02 **Legal category:** P. **PL number:** 10622/0164. **PL holder:** PLIVA Pharma Ltd., Vision House, Bedford Rd, Petersfield, Hampshire, GU32 3QB. For further sales information contact Actavis (UK) Ltd, Whiddon Valley, Barnstaple, North Devon, EX32 8NS. **Date of preparation:** August 2008. **Date of literature preparation:** November 2008.

C+D

Chemist + Druggist

news + education + views for the pharmacy profession

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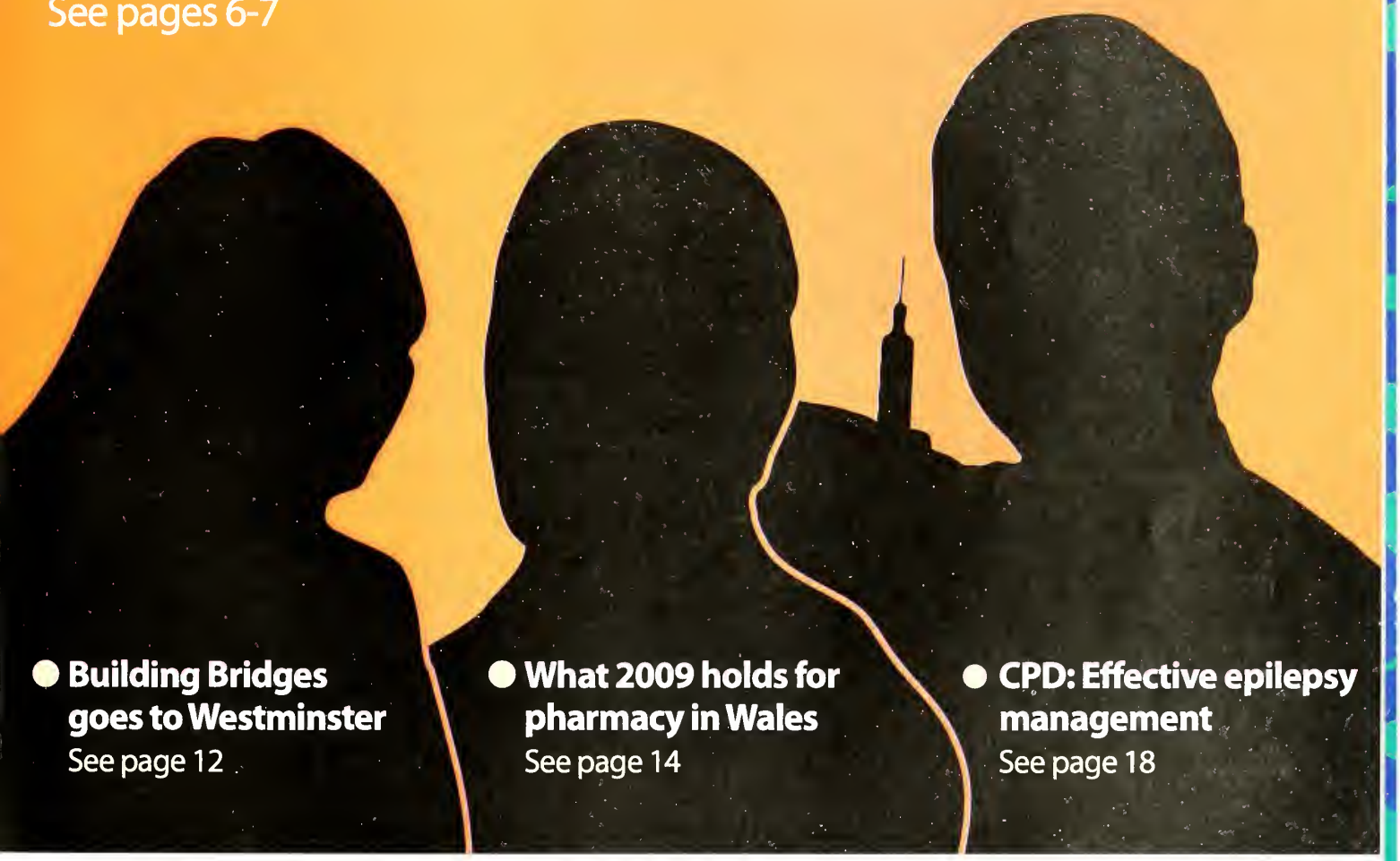
29 November 2008

The new professional body

Will *you* be signing up?

See pages 6-7



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  See page 12
- **What 2009 holds for pharmacy in Wales**
  See page 14
- **CPD: Effective epilepsy management**
  See page 18

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Help your customers stop smoking with NICORETTE® Inhalator nicotine

- Reduces the craving to smoke
- Mimics the hand-to-mouth action of smoking

For every cigarette, there's a nicorette

NICORETTE® Inhalator Product Information: Presentation: Inhalator cartridge containing [illegible] nicotine for inhalation use via a mouthpiece. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. It is used by those wishing to stop smoking immediately and also smokers who need to cut down their cigarette use before stopping. **Dosage: Adults (over 18 years):** No more than 12 cartridges per day. Use when [illegible] to smoke. *Smoking cessation:* 6-12 cartridges per day for 6 weeks. Halve the number of cartridges in weeks 7 and 8. Reduce to zero by end of week 12. Those who use NRT beyond 9 months should consult a healthcare professional. *Smoking reduction:* Use between smoking episodes to reduce smoking. A quit attempt should be made as soon as the smoker feels ready but no later than 6 months. If necessary, advice should be sought if no reduction in 6 weeks or no quit attempt in 9 months. **Adolescents (12 to 18 years):** *Smoking cessation.* As adult dosage, but duration of treatment should not exceed 12 weeks without consulting a healthcare professional. *Smoking reduction:* Only after consulting a healthcare professional. **Contraindications:** Children under 12 years and Hypersensitivity. **Precautions.** Unstable cardiovascular disease, diabetes mellitus, GI disease, uncontrolled hyperthyroidism, phaeochromocytoma, hepatic or renal impairment, chronic throat disease or bronchospastic disease. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and both less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. Best used at room temperature. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Cough, irritation of throat and mouth, headache, nasal congestion, nausea, vomiting, hiccups, palpitations, GI discomfort, dizziness, reversible atrial fibrillation. See SPC for further details. **RRP (ex-VAT):** 6-Starter pack £6.64, 42-Refill pack £21.37. **Legal category:** GSL. **PL holder:** McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **PL number:** 15513/0179. **Date of preparation:** February 2008. **Date of preparation of item:** October 2008 03965

Chemist+Druggist
news education tools

Comment from the Editor

How important are your post-nominals to you? As a chemist (not a pharmacist) I'm proud of being an MRSC, despite it being misread by some who presume I'm a surgeon or a thespian. But if push came to shove, I don't have a public-facing role and a couple of letters after my name doesn't persuade many to trust a journalist more than if I didn't have them.

Some pharmacists are nonplussed about the threat of not having an equivalent of MPharmS after their name if they don't join the new professional body (p6), whereas for others it might be the only reason to sign up. But pull in the protected title 'pharmacist' and now things start getting complicated. How can you explain to a customer when they ask to see the pharmacist, that yes you are a member of the GPhC, however you can't legally call yourself a pharmacist, but, don't worry, you are legit.

Is this reason enough to join? Does the prospectus convince you that a new professional body will have learnt from the mistakes of the current one? Grassroots pharmacists asked by C+D to review the prospectus are generally positive about its content, but interestingly there was little overlap of what they considered to be the 'best bit'. The problem is, a prospectus is useful but it's not until the body is up and running (and knows the income it has to work with) that you will be able to judge it on the delivery of the services it is promising. If you were hoping for lots of detail on what you'll get for your membership fees, you'll be disappointed.

> Does the prospectus convince you that a new professional body will have learnt from the mistakes of the current one?

Unfortunately, the timing could be better – with the busiest month of the year starting on Monday, coupled with a VAT rate cut and accompanying administrative burden – taking your time to consider your options is a luxury for the few. Like it or not, it's decision time.

Fiona Salvage, Deputy Editor

Contents

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Crunch time as Society awaits members' verdict on prospectus

RPSGB promises a body to champion the profession in blueprint document

Jennifer Richardson

The Royal Pharmaceutical Society has published its prospectus for a new professional body for pharmacy.

The document was a "terrific blueprint" for the profession's future leadership organisation, said RPSGB chief executive Jeremy Holmes in a C+D debate.

It promises that the organisation will serve the profession in three areas: representation, professional development, and publications (see panel).

The prospectus, due to be sent to RPSGB members and other stakeholders as C+D went to press, regularly acknowledges members' ongoing dissatisfaction with the Society. It pledges that the new professional body will "redress these shortcomings".

This included making the body a "champion of the profession", with a more significant voice in public policy debate.

The prospectus promises that the body will use "every channel available" to facilitate two-way communication, including an "interactive" website.

"The prospectus is the blueprint for a much more customer-focused organisation. We are listening now and we will continue to listen," said Society president Steve Churton.

The new professional body will take effect when the Society's regulatory role is passed to the General Pharmaceutical Council (GPhC) in 2010. The Society has "proposed" that the cost of joining both the new professional body and registering with the GPhC will be "no more that pharmacists currently pay through their annual retention fee".

The prospectus proposes the development of "local practice forums" to support continuing education by working in collaboration with other local groups such as LPCs, PCOs and CPD providers.

A general and a specialist curriculum committee will support the body in providing professional development services, and the body will provide training for pharmacist management and team leader roles.

Stakeholders can submit their views on the prospectus by January 9, and a vote on charter changes will follow. A two-thirds majority is required for the formation of the new professional body.

The new professional body pledges to provide pharmacy with:

Leadership, representation and advocacy
Promoting the status of the pharmacy profession and ensuring that pharmacy's voice is heard by governments, the media and the public.

Professional development, education and support
Helping pharmacists to advance their careers through accredited training courses, career advice and guidance on good practice.

Professional networking and publications
Creating a series of communication channels to enable pharmacists to discuss issues of common interest.

Join up or lose your professional letters

Those who do not join the new professional body will not be able to use post-nominal letters after their names.

This will be a key incentive to signing up pharmacists to the voluntary organisation, according to the RPSGB. Society chief Jeremy Holmes told a C+D debate on the professional body: "Even if you're on the [regulator's] register, the signal of who you are through those post-nominal letters come from the professional body."

Mr Holmes added: "Pharmacists will come to realise that being on the regulator's list is a licence to practise – but that's not enough."

Pharmacists contacted by C+D backed the importance of post-nominals. Several said it was a significant factor in them joining the professional body.

Scottish Borders-based contractor George Romanes said: "When you're public-facing, I think they want to know that you have done training and are doing training." But contractor Mark Griffiths, of Dowlais Pharmacy, Merthyr Tydfil, said the letters could become less important to pharmacists as more qualified under the new system.

And self-employed pharmacist Catherine Armstrong said it was "farcical" how much emphasis the Society had put on post-nominals. "They need to stop pushing that point so much," she said. **JR**

Your views

C+D asked six pharmacists to rate the prospectus for the new professional body. Had it convinced them to join? What was good about it? And would they stand up and be counted in a vote on its approval or rejection? Here's what they told us:

THE CONTRACTOR:
George Wickham, right, Alphington Pharmacy, Exeter
Will you join? Yes – if only for post-nominals
Best bit? Local co-ordinated working
Will you be exercising your vote? You can't moan unless you vote 6/10

THE SELF-EMPLOYED PHARMACIST:
Catherine Armstrong
Will you join? Yes
Best bit? More information on additional services needed
Will you be exercising your vote? Yes 8/10

THE EMPLOYEE:
Andrew Mawhinney, Lloydspharmacy, Chudleigh, Devon
Will you join? Probably
Best bit? Revalidation support
Will you be exercising your vote? Yes 8/10

Prospectus rating (out of 10):

The future's orange: Society chiefs Jeremy Holmes, left, and Steve Churton, centre, field questions from Ravi Patel during a C+D debate on their plans to turn the RPSGB into the new professional body. To watch the video of the debate, don't miss C+D's digital edition at www.chemistanddruggist.co.uk/digital next week

Proof in delivery, say grassroots

Grassroots pharmacists gave a warm reception to the RPSGB's prospectus for the future professional body this week.

But it remained to be seen whether the organisation could deliver on its blueprint, they told C+D.

"It all seems very good," said Aniket Parikh of Clockwork Pharmacy, London. "It's just in practice whether it will work."

And self-employed pharmacist Catherine Armstrong added: "I'd really like to see it work, and I think it's the way forward, but I'm scared it's going to be the same old story."

In a C+D debate on the plans, Society president Steve Churton assured members they would see change between the old Society and the new professional body.

He said: "I think the worst mistake people can make is to assume that what happens in the future is going to bear a resemblance to what's happened in the past."

Several pharmacists questioned how the proposed "local practice forums" would work. The plans for these seemed "a bit woolly", said contractor George Romanes.

Ms Armstrong added that the local practice forums could lead to a "postcode lottery" of support.

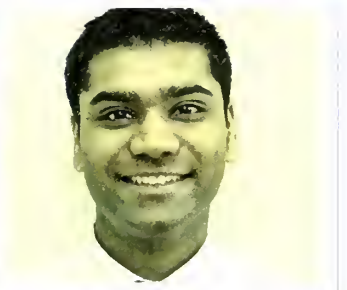
The need for members to feed back their views on the prospectus over the busy Christmas period, by January 9, was "dreadful timing", Mr Romanes added.

The prospectus includes a tear-our return form for feedback. **JR**

Will you be joining the professional body?
jrichardson@cmpmedica.com

THE WELSHMAN:
Mark Griffiths, Dowlais Pharmacy, Merthyr Tydfil
Will you join? Definitely
Best bit? CPD and revalidation support
Will you be exercising your vote? Definitely 8/10

THE SCOTSMAN:
George Romanes, Romanes Pharmacy, Duns
Will you join? Yes
Best bit? Research, communication and national boards
Will you be exercising your vote? Can't moan unless you vote 7.5/10



THE YOUNGSTER:
Aniket Parikh, Clockwork Pharmacy, London
Will you join? Probably
Best bit? Promotion of the profession
Will you be exercising your vote? Yes 8/10

News in brief

White paper views in

Pharmacy leaders have had their say this week on how white paper plans should be moved forward in response to a Department of Health consultation on the proposals which closed last week. To read the RPSGB, CCA, NPA and Dispensing Doctors' Association responses in full go to www.chemistanddruggist.co.uk/whitepaper

IT links lacking

IT links between pharmacists and the wider NHS must improve if the sector is to play a significant part in a national vascular screening programme, MPs have been told. The warning came at a meeting of the all-party pharmacy group on the government's £250 million bid to screen all 40 to 74-year-olds. www.chemistanddruggist.co.uk

Resolution nears in NI

Northern Irish pharmacists are closing in on a deal to end their boycott of minor ailments services. Peace talks between ministers and pharmacy representatives had progressed "very positively" in recent weeks, an industry insider told C+D.

Pre-Budget burden

Contractors have voiced concern over the administrative burden of passing a 2.5 per cent cut in VAT on to customers. Chancellor Alistair Darling announced the cut in the government's pre-budget report this week. www.chemistanddruggist.co.uk

Doctor OTC sales review

The Department of Health is re-estimating the impact of proposals to allow dispensing doctors to sell OTC medicines, following responses to the white paper consultation which closed last week. Pharmacy minister Phil Hope disclosed the work in response to a parliamentary question by shadow pharmacy minister Mark Simmonds.

Alphega convention

Members of Alphega Pharmacy from six European countries recently met at the virtual chain's annual convention, to share best practice. The Alliance Boots-owned group has doubled its size to 1,400 members across Europe, the convention heard.

For the lighter side of dispensing life, visit www.chemistanddruggist.co.uk/postscript

News in brief

OTC Viagra withdrawn

Pfizer has withdrawn an application to make Viagra available without prescription. The European Medicines Agency (EMEA) said it had been "formally notified" of Pfizer's decision to withdraw the application to change the drug's marketing authorisation.
www.chemistanddruggist.co.uk

Phoenix fuel reduction

Phoenix will reduce its fuel surcharge to £4.75 from the start of December. The wholesaler attributed its decision to recent decreases in fuel prices. It first introduced the charge at £9.75 per month in February this year.

Crystal meth problems

The discovery of a crystal meth lab in London this year does not justify switching pseudoephedrine-containing medicines (which can be used to produce the drug) back to POM, Roger Walker, the chair of the working group monitoring the situation, has said. But he warned that the problem had not gone away.
www.chemistanddruggist.co.uk

Boots GP surgery

A GP surgery has been opened in a purpose-built surgery suite within a Boots store in Southampton. Representatives of the local PCT welcomed the venture as an "innovative solution to local needs".
www.chemistanddruggist.co.uk

New Phoenix boss

Phoenix will gain a new European managing director in 2009. Stefan Pflug will take over from Bernd Richter in February next year, the firm announced. Mr Richter has been in the role for the past seven years. Mr Pflug has worked in several businesses within the Phoenix group.

Lloyds' Sugar signs

Sir Alan Sugar's new company, Amscreen, will be launching a series of digital advertising screens in Lloydspharmacy stores. The 15" LED screens will carry adverts and information for customers in the chain's pharmacies in the Birmingham and Oxford regions, as part of a trial deal.

Generic substitution bid sparks liability fears

Legal fears raised over allowing pharmacists to overrule GP scripts

Zoe Smeaton

Generic substitution plan could increase pharmacists' liability, experts fear

Pharmacists could be at greater risk of disciplinary action under Department of Health plans to introduce generic substitution, industry insiders have warned.

Proposals revealed under last week's PPRS deal would allow pharmacists to overrule GP prescribing in some cases. Pharmacists could switch a branded drug for a generic unless the GP had ticked a box indicating only the brand could be dispensed, under DH plans.

David Reissner, a partner in health law specialists Charles Russell, said the additional clinical judgment involved meant there were "potential risks" that pharmacists could be liable if something went wrong and a patient complained. He said in such cases courts would look very carefully at whether pharmacists had followed accepted guidance.

The DH said it would be carrying out impact assessments, and that the scheme would not be introduced until 2010 after discussions with GPs and pharmacists.

John Murphy, director of the Pharmacists' Defence Association, warned the move could put pharmacists "in the firing line". He said they would have to deal with aggression from patients unhappy about receiving generic versions of their medicines, and he called for a public information scheme to back the plans. He said: "This could mean we're walking into an abyss."

Others called for pharmacists to be rewarded for taking on generic substitution. John D'Arcy, interim managing director of Numark, asked: "What's in it for pharmacists? It's widening the portfolio so what do we get for it?" And the NPA agreed the scheme would require "careful implementation" to ensure that pharmacy remuneration was not affected and pharmacists were not unduly burdened.

PPRS cuts 'bad news'

The revised PPRS deal, allowing manufacturers to modulate prices to deliver a 3.9 per cent price cut to the NHS, is "bad news" and has caused yet more uncertainty for contractors, experts have said.

There was also still a risk of stock shortages when the scheme launched, despite it being delayed from January to February, others warned.

Shafique Govani, head of the Beta Buying Group, warned that manufacturers could target price cuts to increase competition with parallel importers, making the effects on the market complex.

Martin Sawer, executive director of the British Association of Pharmaceutical Wholesalers, said the sooner the exact price cut details were communicated by manufacturers the better. This would avoid "shocks to the system". Mr Sawer and AAH welcomed the delay in branded price cuts until February, but AAH said it did not eliminate the risk of medicine shortages over the Christmas and New Year period.

Richard Freudenberg, secretary-general of the British Association of European Pharmaceutical Distributors, was concerned by price cuts but added that a "10 per cent [cut] was being suggested, so in that context it's not too bad". **ZS**

Will revised deal prevent stock shortages?
zsmeaton@cmpmedica.com

Welsh plans

Community pharmacists in Wales could see savings made by the NHS through the new PPRS deal reinvested back into the profession.

Jeremy Savage, deputy chief pharmaceutical advisor to the Welsh Assembly Government, told C+D the PPRS cuts would be a "very welcome increase to our budget". And he added: "We're hoping to reinvest some of those savings into our community pharmacy network."

However, he warned pharmacists to be under no illusions about the current economic climate and said there was "a challenge to ensure that the resources we do have are used effectively".

Alastair Buxton, head of NHS services at PSNC, said the committee would be discussing other matters around the PPRS "before we start to consider how any savings could be redeployed in the NHS". **ZS**

Find out why Mike Hewitson is knee-deep in rubbish at:
www.chemistanddruggist.co.uk/openmike

Dispensary TALK

Is lack of privacy putting patients off pharmacies?

"Accessibility balances it out. We can't take everyone into a consultation room – you would never have enough time to see everyone. But what draws people to pharmacy is that it's accessible."
Ian Gabbie, Gabbie Pharmacy, Killyleagh, Northern Ireland

"I don't think people would be put off and they will ask if they want to be seen in private. But I also think it would be good if we could promote the fact that pharmacies have private areas. If we raise awareness people will know the option is there."
Roy Gillman, Sheffield Pharmacy, Hertford

WEB VERDICT:

Yes	20%
No	76%
Maybe	4%

Armchair view: Pharmacy has no problem with privacy, according to over three-quarters of poll respondents. This contrasts with views reported in a Patient Association survey last week. With consultation areas coming as standard in many pharmacies, perhaps it's time the sector promoted the private areas to the wider public.
Next Week's question: Has the new professional body prospectus convinced you to join? Vote at www.chemistanddruggist.co.uk

Pharmacy chiefs maintain dispensing GP alliance

White paper plans to overhaul dispensing rules rejected by DDA and PSNC

James Clegg

Pharmacy leaders have maintained their alliance with dispensing GPs this week as doctors' representatives stepped up opposition to pharmacy white paper plans.

The PSNC and Dispensing Doctors' Association (DDA) presented a united front as they briefed ministers on the document at Westminster on Tuesday.

The organisations told MPs they wanted "no change" to rules that allow surgeries to dispense where patients live over a mile from the nearest pharmacy.

The accord came as the DDA published a survey that claimed 95 per cent of patients were opposed to plans in the pharmacy white paper to overhaul these restrictions.

Dr David Baker, DDA chief executive, said the organisations had a "united front" on the issue, despite some aggressive lobbying by dispensing doctors at local level.

He said: "We don't want to turn the clock back and have GPs and pharmacists at each others throats." Commenting on the results of the DDA survey, Dr Baker added: "The impact of proposed changes is at stark odds with the government's laudable ambition to personalise health service and improve choice and access to patient care."

The DDA survey questioned 6,000 patients from 100 dispensing surgeries. Steve Lutener, PSNC head of regulation, said the organisation was committed to no change in regulations governing dispensing doctors. But, Mr Lutener added: "I don't know if we'll be supportive of everything the DDA say on the white paper."

Asked if he was concerned about the level of publicity the DDA's lobbying efforts, including the survey itself, had generated, Mr Lutener said: "They're making sure that part of what they do doesn't disappear with the white paper. If the boot was on the other foot I'm sure we would do the same."

Put a pharmacist in the surgery, says DDA

The Dispensing Doctors' Association (DDA) has suggested considering the benefits of putting a pharmacist, though not necessarily a pharmacy, in every GP surgery, in response to white paper proposals.

The move could help bring pharmacists closer to the primary healthcare team, the DDA said. The comments came as the organisation gave its official response to the Department of Health consultation on April's pharmacy white paper.

"Millions of patients" would face cuts in services if proposals outlined in the white paper went ahead, the DDA warned.

The association said plans to restrict the number of dispensing practices would "overall reduce patients' access and choice". **ZS**

MLA John McCallister, centre, dons the white coat during a Building Bridges visit to the Annalong Pharmacy in County Down. The Ulster Unionist Party health spokesperson met with pharmacy owner and Pharmaceutical Contractors' Committee chairman Tim Corrie, right. The duo discussed the continuing boycott of minor ailments services by local contractors and the future of generic tendering in Northern Ireland. Mr Corrie told C+D: "It was a really great opportunity to talk about pressing matters for pharmacists in Northern Ireland at the moment." Also pictured is Annalong pharmacist manager Martin Mallet, left

See C+D readers quiz the RPSGB's chief executive and president in our Question Time special in C+D's digital edition on December 6

C+D digital edition C+D's next online-only issue – December 6

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Building Bridges goes to Westminster

Pharmacists and MPs met up last week to celebrate C+D's campaign to boost the profession's political profile. **Max Gosney** reports on the impact of Building Bridges

Photo - Chris Sharp

Our Building Bridges campaign has focused on getting MPs out of Westminster to visit their local pharmacy. But last week roles were reversed as pharmacists travelled to the Houses of Parliament to see ministers at their workplace. Sixteen pharmacists who hosted MP visits attended a C+D/All-Party Pharmacy Group (APPG) meeting to mark the success of the Building Bridges campaign. Over 40 MPs have met local contractors since the initiative launched in February.

Howard Stoate (top right), chair of the APPG, said the campaign had played an important part in showcasing the skills of pharmacists to MPs. Dr Stoate said he would like to see all of his colleagues at Westminster get out to visit a pharmacy.

Sandra Gidley (left, second from bottom), APPG treasurer and the first MP to take part in a Building Bridges visit, thanked C+D for helping to raise the political profile of pharmacists through the campaign.

The profession had traditionally struggled in this area, MPs reflected. This could be explained in part by a characteristic shyness among the profession, Dr Stoate said. "You're not typically extroverts. I once heard a joke that you can tell a pharmacist is an extrovert because he's the one looking at your feet."

Pharmacists told the meeting how they had benefited from getting to know their MP through Building Bridges. Visits had triggered parliamentary questions over issues impacting on local contractors, the meeting heard. George Wickham revealed how hosting health minister Ben Bradshaw at his Devon pharmacy had led to a more pharmacy-friendly outlook from his PCT on vascular screening.

The meeting concluded that pharmacy must keep up the dialogue with Westminster. To help the cause, C+D will continue to bring MPs and pharmacists together through the Building Bridges campaign. But we need your help. To volunteer for an MP visit email mgosney@cmpmedica.com or visit www.chemistanddruggist/buildingbridges

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PRESCRIBING INFORMATION. XENICAL (orlistat). Indications: XENICAL is indicated in conjunction with a mildly hypocaloric diet for the treatment of obese patients with a BMI ≥30 kg/m², or BMI ≥28 kg/m² with associated risk factors. Treatment should be discontinued after 12 weeks if patients have been unable to lose ≥5% of their body weight. **Dosage and administration:** One capsule immediately before, during or up to one hour after meals (only 30% of calorie intake from fat). **Contra-indications:** Chronic malabsorption syndrome, cholestasis, breast-feeding, known hypersensitivity to any component of the product. **Precautions:** Monitor anti-diabetic drug treatment. Co-administration of orlistat with ciclosporin is not recommended. Treatment may potentially impair the absorption of fat-soluble vitamins (A, D, E, and K), patients should be advised to have a diet rich in fruit and vegetables. The possibility of experiencing gastrointestinal events may increase when orlistat is taken with a diet high in fat. Caution should be exercised when prescribing to pregnant women. Studies have shown no interaction between orlistat and oral contraceptives, however an additional contraceptive method is recommended to prevent possible failure of oral contraception that could occur in case of severe diarrhoea. Rare cases of rectal bleeding, generally of mild intensity have been reported and prescribers should investigate further if symptoms are severe or persistent. **Drug Interactions:** A decrease in ciclosporin levels has been observed in an interaction study. Co-administration with acarbose should be avoided. INR values should be monitored if patient is on warfarin or other anticoagulants. Reinforcement of clinical and ECG monitoring is warranted if patient is on amiodarone. **Side-effects:** Please consult the Summary of Product Characteristics for full details of adverse events. **Common:** Influenza, anxiety, headache, respiratory infection, urinary tract infection, menstrual irregularity, fatigue and gastrointestinal such as oily spotting, abdominal pain, increased defecation and flatulence. Treatment adverse events in type 2 diabetics included hypoglycaemia and abdominal distension. The incidence of adverse events decreased with prolonged use of orlistat. **Serious:** Very rare cases of increases in liver transaminases and alkaline phosphatase and also cases of hepatitis. Very rare cases of bullous eruptions, diverticulitis and cholelithiasis. Rare hypersensitivity reactions of angioedema, bronchospasm and anaphylaxis. **Legal Category:** POM. **Presentation and Basic NHS Cost:** Xenical 120mg (84 capsules) £33.58. **Marketing Authorisation Number:** EU/1/98/071/003 (84 capsule blister pack). **Marketing Authorisation Holder:** Roche Registration Limited, 6 Falcon Way, Shire Park, Welwyn Garden City, AL7 1TW, UK. Further information is available on request. Xenical is a registered trade mark. **Date of preparation:** July 2008.

References: 1. Data on file, Xeni 1008. **2.** Torgerson JS et al. Diabetes Care 2004; 27: 155-161. **3.** Hollander PA et al. Diabetes Care 1998; 21: 1288-1294. **4.** Hauptman J et al. Arch Fam Med 2000; 9: 160-167. **5.** Rossner S et al. Obes Res 2000; 8: 49-61. **6.** Xenical Summary of Product Characteristics, June 2008.

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XENI00009g November 2008.

Watching Wales

As a rocky year for pharmacy, with funding uncertainties and a whole range of service developments, nears its end, **Zoe Smeaton** asks what the future holds for contractors in Wales, where a busy 2009 seems a likely prospect

After the highs and lows of the last 12 months, with good news such as the white paper then countered by the category M crisis, many pharmacists will be hoping that stability is a key theme in 2009. This looks fairly unlikely in all quarters, with key new services due to be rolled out, a new professional body and countless other developments pencilled in for next year, but for one country in particular it is a definite no-no.

Jeremy Savage, deputy chief pharmaceutical advisor to the Welsh Assembly Government (WAG), says the next 12 months offer a range of exciting opportunities for pharmacists in Wales, but are likely to bring a lot of change as the NHS undergoes major reorganisation. The NHS Trusts and 22 existing local health boards are to be fused into just seven new organisations which will be overseen by a national advisory board and separate delivery group. As Mr Savage says: "It's interesting times, there are going to be some challenges and some opportunities."

There are lots of positives, Mr Savage predicts. Fewer health organisations could mean fewer people for pharmacists to convince of their abilities to deliver health services, he says. There could also be opportunities for the profession to have a direct influence over the planning of services by taking positions within the new structures, Mr Savage suggests.

He says there is a "real will" from the government for pharmacists "to be promoted and visible within the new organisations". One thing that could prove helpful is a government-backed scheme in Wales to promote national leadership and innovation skills among pharmacists.

Despite these positive signs, it is unlikely to be an easy journey. While the changes certainly bring opportunities, Mr Savage warns that making strong links with the new organisations will take some effort. He says: "To build new relationships with new masters is always a challenge, and people will need to be seen to be developing services and being positive about pharmacy."

> "To build new relationships with new masters is always a challenge"

Furthermore, with all the focus on setting up the new bodies, it may be difficult to move specific pharmacy developments forward very quickly. For example, Mr Savage says one thing the country needs to revisit is its control of entry arrangements, which are distinct from those in England. But he warns: "Because of the transition period within the NHS it's going to be difficult [in the next year] to get a focus on the specifics of things like pharmacy regulations." Significant progress is unlikely before the later part of next year.

So just how might pharmacy look by the end of next year? Will Wales follow the lead of its larger neighbour or take its own route?

Some developments from across the border will undoubtedly impact on Welsh contractors. For example, Mr Savage says Wales, like England, will see an increasing drive for quality in the NHS. "We're very much signed up to that," he says. While he says enhanced services are doing well in Wales, with a template for chlamydia screening currently being produced, it is unclear yet whether services such as vascular screening, which has received so much attention in England, will feature high on the Welsh agenda too. He says: "We have been in discussion on a number of issues that have been published in the white paper and there are already elements we are wanting to pursue." But he adds: "There's a lot of debate going on about some of the screening activities and the role that pharmacy can play in that. It's being discussed, but I wouldn't go any further than that yet."

The key difference between the two countries though, he says, is the focus on collaboration in Wales, and this is good news for pharmacists. He says there is a "completely different culture" in the NHS in Wales, with the emphasis being more on working in partnership than in competition. The new health organisations will be focused on planning, rather than commissioning services, and there are likely to be more consistent services across the country. Mr Savage says a key message from the government is the need to remove health inequalities and "ensure patients have access to services consistently across Wales". To ensure this happens he says there is likely to be a clear steer from the central NHS board on what is expected, with the new local health organisations being "directed a lot more" as to what services they should be delivering.

The profession will be further boosted by support from the highest levels, being key to both public and rural health strategies. "The One Wales document [a coalition agreement for the National Assembly for Wales, setting out a plan to improve the quality of life for the nation] mentions pharmacy, which is a very positive thing. It identifies community pharmacy as a focus for health services in the country," Mr Savage says. And he adds this, combined with the good working relationships within the profession, will help to push development in pharmacy forwards.

So despite some challenges, such as building relationships with new commissioners, there is plenty of cause for pharmacists to be upbeat. Mr Savage says it's a positive outlook for the profession in "the brave new world of the NHS in Wales". And, as he concludes: "Pharmacists should be optimistic."

Based in Wales? What will 2009 deliver?
zsmeaton@cmpmedica.com

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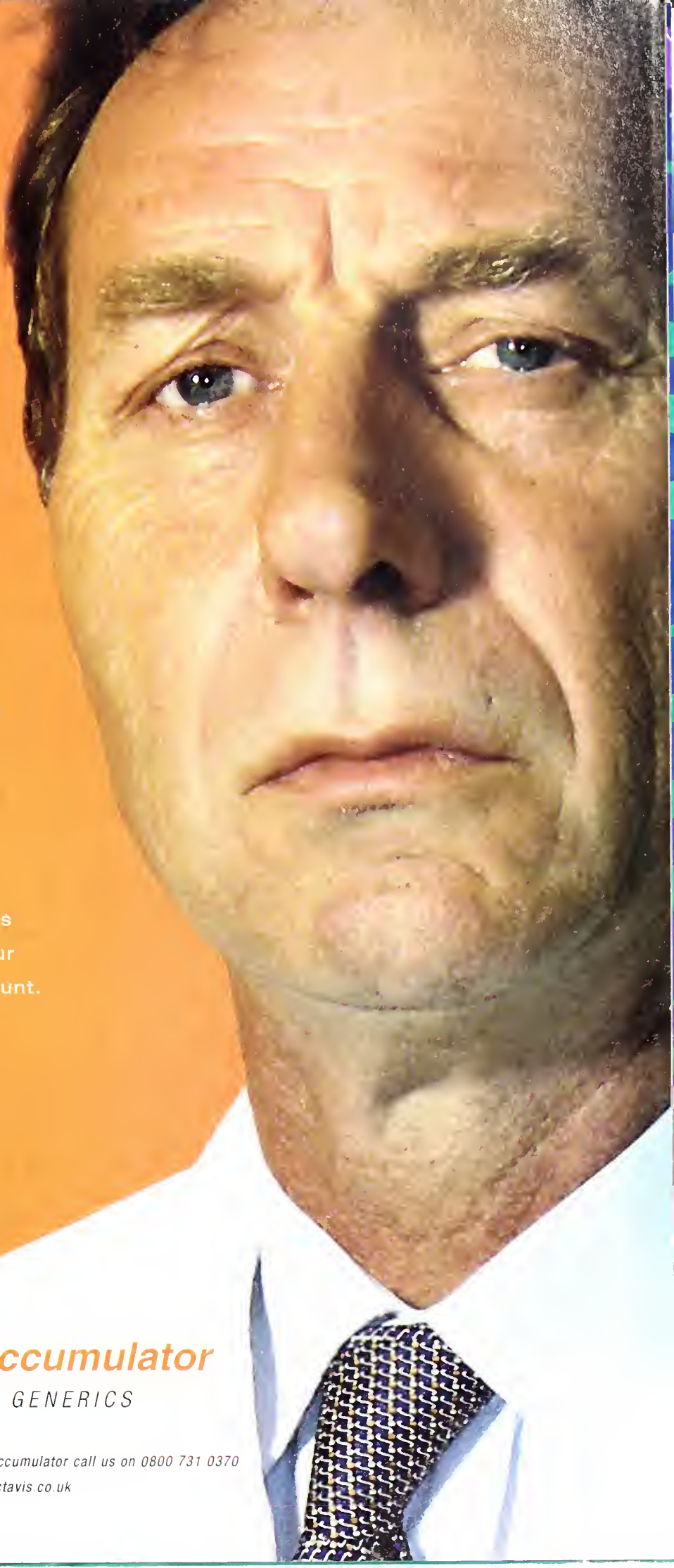

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Juggling so many balls I could join the circus

Privacy and confidentiality are big issues in community pharmacy, as the Patients Association has correctly identified (C+D, November 22, p6). There are no easy answers.

Consultation rooms are a great step forward but, without an appointment system, most conversations in most pharmacies have to take place somewhere near the front counter. If patients want instant access to a pharmacist, a counter assistant or their prescription, this is the price they must pay. Replacing the pharmacy front of shop with a GP waiting room scenario simply will not work with existing premises and funding.

We have to work with what we've got, and dealing with patient queries requires a great deal of sensitivity and experience. Most people are happy to discuss their cough in detail, regardless of who might be listening. But some people are reluctant to discuss any health issue other than in hushed tones, face to face in a room with the door shut. Others are happy to share their most intimate health concerns with anybody within earshot. It's our job to assess each patient individually.

The NPSA's recommended layout for the ideal pharmacy counter involves one which is very long, with no product shelving, two computer terminals and a barrier at one end to create some privacy when the pharmacist hands out prescriptions. It looks fantastic and I'd love to work in a pharmacy like that. But this isn't the reality in most pharmacies, which have struggled to find a corner for anything resembling a consultation area.

Calling out names and addresses as scripts are handed out does seem a rather coarse modus operandi but there's no viable alternative. Handing out tickets, deli counter style, simply holds things up and creates more potential for errors. The receptionist at the surgery calls out patient names anyway – I've never heard anyone complain about that. And there are easier ways to discover someone's address than wait around at the pharmacy till it's shouted out.

> "The largest juggling balls are time and workload"

We're constantly juggling so many balls, – safety, time, workload, patient privacy – that something has to give. The largest juggling balls are time and workload, so privacy is often the one that's sacrificed. It's a question that arises many times every day – shall I take that patient into the consultation room for a five-minute discussion and make 10 patients (and the doctor on the phone) wait longer than necessary, or shall I deal with them in a minute at the counter? It's usually the second option and there's not much I can do about it.

My message to patients is simple: if you want a confidential discussion ask to talk with the pharmacist in the consultation room but you may have to wait a few minutes for this. Otherwise, you must trust that the pharmacy staff are doing their best to deal with you as sensitively as they can.

Devastation and chaos – just another day at the pharmacy

Having worked in over 100 pharmacies since my locum days started, I have probably seen the best and worst of community pharmacy. On my way to yet another new location I always wonder what I am going to find when I get there, but two recent instances have really got me in Victor Meldrew mode.

I arrived at the first branch of a well known multiple at the appointed hour, walked in to the dispensary and was met by a scene of devastation and chaos. Wholesaler boxes in various stages of being emptied were strewn all over the floor, with the lids dumped anywhere.

The shelves were an utter mess, with boxes all over the place and virtually nothing stacked tidily in any semblance of order. The dispensary bench, all three feet of it, was buried under a mountain of invoices, journals and general bumf. The computer keyboard was covered in dust, the screen likewise. Hasn't anyone ever heard of cleanliness and hygiene?

The floor was filthy (what I could see of it) and clearly had not been swept for days, perhaps weeks. Empty dosage trays were strewn everywhere. Staff straggled in lazily and reluctantly, taking an age to appear from the cluttered staffroom in either the dispensary or at the counter. Introducing myself, I was met with a grunt or nod, but never a smile or a word of welcome. No-one all day said a friendly word or offered as much as a cup of tea. I was clearly 'the locum', that lowest form of animal life, here today, gone tomorrow. Dispensing was obviously an unwelcome chore, labels slapped on any old how, upside down, crooked or overhanging the container. When I remarked on this, back snapped the response: "Well, they can read it, can't they?"

> "I staggered out of the building at closing time absolutely exhausted"

Never have I been so glad to leave anywhere at closing time. However, one junior member of staff did at least deign to say goodbye as I walked out the door.

Pharmacy number two, sadly from the same company, was very much the same but monstrously understaffed for the volume of counter and dispensing work it conducted.

The shop was full of unopened boxes of stock that no one had the time or inclination to put away, or space from what I could see. Shelves were crammed with merchandise, especially toys, games, novelties etc – the place more resembled a bazaar than a pharmacy. Christmas stock had arrived and no-one had a clue where it was to go as space was at a premium.

The small stockroom was bursting at the seams and even the toilet was used as an overflow store room. I was appalled. Would you want to buy anything that had been stored in a toilet?

Busting a gut all day long coping with a torrent of prescriptions, addicts, trays, phone calls, customer queries, endless complaints about un-arrived repeats etc, I staggered out of the building at closing time absolutely exhausted, having hated every minute of it.

That is not my idea of how community pharmacy should be allowed to operate. The second branch was at least 50 per cent understaffed, with a high risk of dispensing errors.

On arriving home from the last pharmacy I regaled my wife with my experiences. She suggested that I had a word with Which? and suggest to them that they might like to spend a few hours in certain pharmacy dispensaries.

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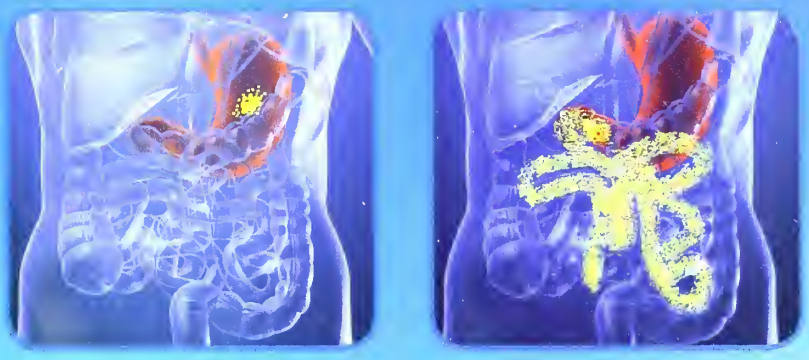

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Panadol is a trade mark of the GlaxoSmithKline group of companies.

Reference:
1. Wilson C et al. Abstract PH 217, International Association for the study of Pain 12th World Congress on Pain, Aug 2008.

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C+D Clinical

Effective epilepsy management

Following last week's Update on diagnosis and symptoms, we turn to the anti-epileptic treatments

Key points

- Anti-epileptic drugs (AEDs), the mainstay of treatment, act on chemical processes in the cerebral neurones to dampen down electrical activity in the brain.
- Dosing regimens are complex and require careful balancing, starting with low doses and increasing gradually until seizures are controlled or significant adverse events emerge.
- Non-drug and lifestyle interventions can prove useful.
- Adherence to prescribed regimens is one of the key determinants of effective long-term control.

Helen Boreham

Early medical management of epilepsy relied solely on maintaining patients on a high fat, low carbohydrate diet known as the ketogenic diet – the only means available to alter the brain's chemical composition and make seizures less likely.

The discovery of phenytoin in the 1930s sparked a revolution in treatment and, since that time, a succession of effective anti-epileptic drugs (AEDs) have evolved to become mainstays of modern management.

Anti-epileptic drugs

AEDs control seizures by damping down the electrical excitability of the brain, and are successful for many patients. Most are prescribed for everyday seizure control while others, such as diazepam or midazolam, tend to be reserved for emergency use. Treatment is not usually initiated until after a second seizure has occurred, providing a reliable indicator of epilepsy.

The College of Pharmacy Practice

This course (module 1457), in association with multiple choice questions being published in C+D November 29, provides one hour's continuing education

Reflect

Which type of seizure can be treated by ethosuximide? What are the side effects of vigabatrin?Which anti-epileptic drugs have a once-daily dosage? How can vagus nerve stimulation help control epilepsy?

Plan

This article covers the drugs available for the treatment of epilepsy, the type of seizures they can treat, their dosage regimens and side effects. There is also useful advice on the pharmacist's role in epilepsy management.

CPD This article can help in the following CPD competencies: **G1a, G1c, G1d, C1b, C1c, C3e.** See http://tinyurl.com/68ox7b

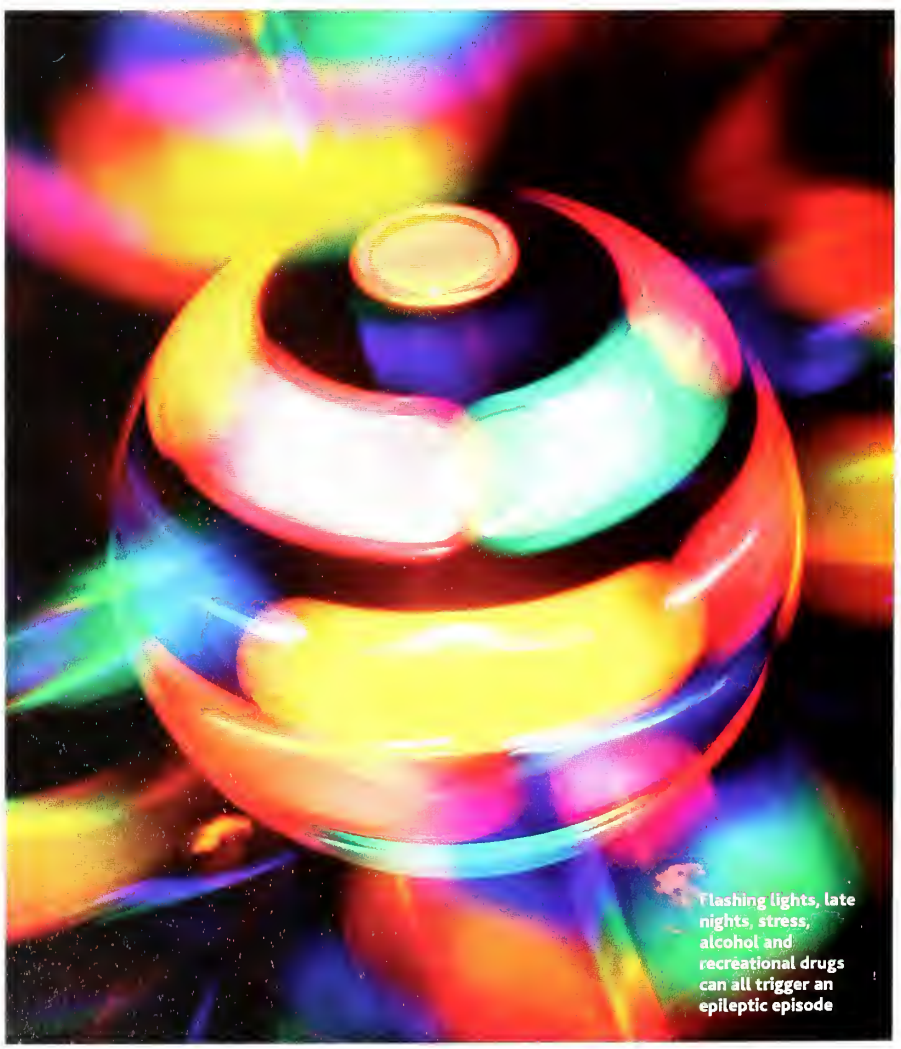

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TABLE 1: MAJOR AEDS – DOSING AND INDICATIONS[1,2]

Drug	Adult dose	Indication*
Acetazolamide [+ modified-release]	0.25–1g daily in divided doses	• Specific role in treating epilepsy associated with menstruation • Also used with other anti-epileptics for tonic-clonic and partial seizures • Occasionally helpful in atypical absences, atonic and tonic seizures
Carbamazepine [+ modified-release]	100–200mg one to two times daily, increased slowly to usual dose of 0.4–1.2g daily in divided doses; in some cases 1.6–2g daily may be needed	• Partial and secondary generalised tonic-clonic seizures • Primary generalised seizures
Clobazam	20–30mg daily; max. 60mg daily	• Adjunct in epilepsy
Clonazepam	1mg at night for four nights, increased according to response over two to four weeks to usual maintenance dose of 4–8mg (may be given in three to four divided doses)	• All forms of epilepsy
Ethosuximide	500mg daily increased by 250mg at intervals of four to seven days to usual dose of 1–1.5g daily; occasionally up to 2g daily may be needed	• Absence seizures
Gabapentin	300mg on day one, 300mg twice daily on day two, 300mg three times daily on day three, then increased according to response in steps of 300mg daily (in three divided doses) every two to three days. Usual dose 0.9–3.6g daily in three divided doses (every 8 hours)	• Monotherapy and adjunctive treatment of partial seizures with or without secondary generalisation
Lacosamide	Initially 50mg twice daily increased maintenance of 100mg twice a day after one week. Can be further increased in increments of 50mg twice daily every week to 200mg twice daily	• Adjunctive therapy in partial-onset seizures with or without secondary generalisation in patients aged 16 and over
Lamotrigine	As monotherapy – 25mg daily for 14 days, increased to 50mg daily for further 14 days then increased by a maximum of 50–100mg daily every seven to 14 days. Usual maintenance 100–200mg daily in one to two divided doses	• Monotherapy and adjunctive treatment of partial seizures and primary and secondary generalised tonic-clonic seizures • Seizures associated with Lennox-Gastaut syndrome
Levetiracetam	As monotherapy – 250mg twice daily increased according to response in steps of 250mg twice daily every two weeks maximum. 1.5g twice daily	• Monotherapy and adjunctive treatment of partial seizures with or without secondary generalisation • Adjunctive therapy of myoclonic seizures and generalised tonic-clonic seizures
Oxcarbazepine	300mg twice daily increased according to response in steps of up to 600mg daily at weekly intervals; usual range 0.6–2.4g daily in divided doses	• Monotherapy and adjunctive treatment of partial seizures with or without secondary generalised tonic-clonic seizures
Phenobarbital (phenobarbitone)	60–180mg at night	• All forms of epilepsy except absence seizures
Phenytoin	3–4mg/kg daily or 150–300mg daily (single or two divided doses) increased gradually as necessary (with plasma-phenytoin concentration monitoring); usual dose 200–500mg daily	• All forms of epilepsy except absence seizures
Pregabalin	25mg twice daily, increased at seven-day intervals in steps of 50mg daily to 300mg daily in two to three divided doses, increased further if necessary after seven days to maximum. 600mg daily in two to three divided doses	• Adjunctive therapy for partial seizures with or without secondary generalisation
Primidone	125mg daily at bedtime, increased by 125mg every three days to 500mg daily in two divided doses, then increased according to response by 250mg every three days to usual maintenance 0.75–1.5g daily in two divided doses	• All forms of epilepsy except absence seizures
Rufinamide	Body-weight over 30kg: 200mg twice daily increased according to response in steps of 200mg twice daily at intervals not less than two days. Body-weight 30–50kg, max. 900mg twice daily; 50–70kg, max. 1.2g twice daily; over 70kg, max. 1.6g twice daily	• Adjunctive treatment of seizures in Lennox-Gastaut syndrome

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Sodium valproate [+ modified-release]	600mg daily in two divided doses, preferably after food, increased by 200mg daily every three days to a maximum of 2.5g daily; usual maintenance 1–2g daily (20–30mg/kg daily)	• All forms of epilepsy
Tiagabine	With enzyme-inducing drugs: 5mg twice daily for a week, increased at weekly intervals in steps of 5–10mg daily; usual maintenance 30–45mg daily (doses above 30mg given in three divided doses) With non-enzyme-inducing drugs: initial maintenance dose 15–30mg	• Adjunctive treatment for partial seizures with or without secondary generalisation not satisfactorily controlled with other anti-epileptics
Topiramate	25mg at night for a week, increased in steps of 25–50mg daily at intervals of one to two weeks taken in two divided doses; usual dose 100mg daily in two divided doses; max 400mg daily	• Monotherapy and adjunctive treatment of generalised tonic-clonic seizures or partial seizures with or without secondary generalisation • Adjunctive treatment of seizures in Lennox-Gastaut syndrome
Vigabatrin	1g daily in single or two divided doses, increased according to response in steps of 500mg at weekly intervals; usual range 2–3g daily (max 3g daily)	• Initiated and supervised by appropriate specialist – adjunctive treatment of partial seizures with or without generalisation not adequately controlled with other anti-epileptic drugs • Monotherapy for management of infantile spasms (West's syndrome)
Zonisamide	50mg daily in two divided doses, increased after seven days to 100mg daily in two divided doses; increase if necessary by 100mg every seven days; usual maintenance 300–500mg daily in one or two divided doses	• Adjunctive therapy for refractory partial seizures with or without secondary generalisation

See BNF for adjunctive dosing details

*See C+D Pharmacy Update last week for definition of types of seizures.

Anti-epileptics in action

The key objective is to prevent seizures by maintaining an effective dose of one or more AEDs. When choosing which anti-epileptic to use from the wealth of options available, seizure type, concomitant medication, age, sex and pregnancy status must all be taken into account.

Concurrent therapy with two or more AEDs may be necessary. Combination therapy is usually employed where a patient has failed on monotherapy with two first-line AEDs or where a well-tolerated first-line anti-epileptic significantly improves seizure control but the patient is not seizure-free despite taking the maximum-tolerated dose.

Despite proven clinical efficacy, the precise mechanism of action remains unclear. Broadly speaking, AEDs seem to work either by enhancement of GABA-mediated inhibition of neuronal excitability (eg benzodiazepines, vigabatrin, phenobarbitone and valproate) or via a reduction in sodium fluxes across nerve cells (eg phenytoin, carbamazepine, valproate and lamotrigine).[3] Ethosuximide and valproate may also inhibit spike-generating calcium currents in thalamic neurones.[3]

The delicacy of dosing

Optimal management requires careful dose adjustment, starting with low levels and increasing gradually until seizures are controlled or significant adverse events emerge. Resulting regimens are often complex and varied (see table 1). Where possible, dose frequency should be kept as low as possible to encourage compliance. Most AEDs are given twice daily, while those with longer half lives such as lamotrigine, phenobarbital and phenytoin can be taken once daily at bedtime. Where larger doses are required, AEDs may need more frequent dosing to avoid the adverse effects associated with high peak plasma concentrations. Young children metabolise anti-epileptics more rapidly than adults so require proportionally more frequent and higher doses.

Because of the subtlety of dosing, effective epilepsy management will often require regular patient monitoring. Phenytoin in particular has a narrow therapeutic index and, because the relationship between dose and plasma concentration is non-linear, small dose increases in some patients may produce large rises in plasma concentrations with acute toxic side effects. Monitoring of plasma concentration greatly assists dosage adjustment as just a few missed doses or a small change in drug absorption may result in a marked change in plasma concentration. For certain AEDs – such as sodium valproate and phenobarbital – monitoring is less useful as plasma concentrations do not offer a meaningful index of drug efficacy.

Side effects

Side effects are common when first starting treatment but normally lessen after a few days. Typically these include nausea, abdominal pain, drowsiness, dizziness, irritability and mood changes. Certain symptoms can indicate that the dose is too high; for example unsteadiness, poor concentration, drowsiness, vomiting and double vision. Other noteworthy side effects are specific to the AED:

- Lamotrigine may cause serious skin rash especially in children.
- Phenytoin may cause acne, hirsutism and gingival hyperplasia – making it particularly undesirable in adolescents.
- About one-third of patients treated with vigabatrin suffer visual field defects. It may also induce prominent behavioural side effects.
- Clonazepam is particularly sedative.

Combination therapy enhances toxicity, raises the risk of side effects and may give rise to drug interactions between the anti-epileptic agents themselves (see BNF for full details). Where side effects prove particularly problematic, changes to the timing of medication and/or use of modified-release formulations may help.

Non-drug and lifestyle approaches

Although AEDs are the lynchpin of medical treatment, non-drug approaches can also ▶

Newsletter

NOVEMBER 2008

From the chair

"Look not mournfully into the past, it comes not back again. Wisely improve the present, it is thine. Go forth to meet the shadowy future without fear and with a manly heart."
Henry Wadsworth Longfellow

College chairman David Morgan

Thank you for your contributions

Many College members and associates have participated in the development of the new professional body (NPB), either by participating in the various surveys and consultations or involvement in the TransCom infrastructure.

I would like to extend my thanks to all those who have contributed, especially to those who have worked to a very exhausting timetable over the summer months.

The College chief executive Ian Simpson has been in the thick of the debate as a TransCom member and also as chairman of the Improved, Advanced and Specialist Practice Working Group.

Way forward

The College has consistently been a fervent supporter of the development of the new body and has publicly expressed its intention to merge with other like-minded organisations to form the NPB.

The way forward is gradually becoming clearer. In late October, TransCom approved a prospectus for the NPB and it is anticipated that Council will approve the prospectus at its November meeting (there is no plan B!). Following this, there will be a wider consultation with all RPSGB members on the content of the prospectus including:

- Why pharmacy needs a NPB
- How is the new body different from the existing arrangements
- Who are eligible to become members and/or affiliates
- The core services for members
- The structure including a central Assembly, three National Boards and local support arrangements
- The initial arrangements for establishing the NPB, such as how to join, and elections.

Beyond the consultation the arrangements are less clear. Changes to the Charter will need to be made in 2009. No more meetings of TransCom are scheduled on its website. Who is going to manage the transitional period up until the formation of the NPB?

The publication of the Pharmacy Section 60 order has been delayed

continued overleaf

In this issue

Membership of the College

Members of the College of Pharmacy Practice share a common interest in achieving a high standard of practice and must give a commitment to participate in continuing professional development.

Practising pharmacists are eligible to join as associates and may then proceed to membership and eventually fellowship of the College.

Membership by practice is now the method of choice for Associates proceeding to membership.

Full details of membership are available from the College office or from the College website – *www.collpharm.org.uk*.

Tel: 024 7622 1359

E-mail: *info@collpharm.org.uk*

CPP News

Continued from front page

and this will affect the establishment of the new regulator, The General Pharmaceutical Council (GPhC). It is anticipated this will not be achieved in January 2010 but some time in "early 2010". Consequently there will be a knock-on effect on the establishment of the NPB.

What can we expect?

The NPB will not be a re-branded RPSGB but a completely re-invented new body that should regain the support of potential members. The functions of the NPB will be approved following the consultation and this will enable its structure to be developed.

The NPB will need a new name and this should be determined by its members. TransCom has proposed that the central governing body should be called an Assembly rather than a Council and should meet less frequently. The three National Boards will have some flexibility in determining their composition.

All members will be supported throughout their professional careers by a General or Specialist Board to improve their practice or to become advanced or specialist practitioners. Local leadership and networking will be developed through Local Practice Boards (formerly called Local Branches).

The membership fee will pay for a range of common core services including:

- Professional and career development support, such as CPD and revalidation.
- Use of post-nominals, which will depend on the name of the NPB.
- Access to information, library, networking and benevolence services.
- Research, education and training.
- Leadership, representation and advocacy.
- Regulatory support to members to comply with GPhC requirements as registrants.

Different membership categories will attract different fees. Non-core services will require additional funding e.g. Return to Practice courses, mentoring, the BPC and publishing activities.

The activities of the NPB will have to be fully supported by members' fees and this will be of direct concern to members. We hope that the combined fees for the GPhC and the NPB will be equivalent to the existing RPSGB fee but the regulator, however, has the power to set its own fees. Actual fees payable will become apparent during the transitional period when the fee is split between the two new bodies.

Looking forward to the next year, we have generated lots of good ideas and discarded those that are not so useful. The new arrangements are becoming clearer now and hopefully we will embrace them with enthusiasm. We may not love the regulator but we must love the NPB.

David Morgan
Chairman, College of Pharmacy Practice

NEWS IN BRIEF

e-Bulletins

The College is aiming to send regular e-Bulletins to all members. If you have not received any e-Bulletins, there could be a number of reasons:

- We do not have your email address
- You have changed your email address and you have not told us
- Your server is rejecting College emails as 'junk'.

If you think there is a problem with your server accepting College emails (we have found this happening with NHS servers), you might wish to give us your personal email address instead. Alternatively, you could contact your IT department and ask them to make sure that College emails get through you. Please contact info@collpharm.org.uk to update your details.

External verifiers – BTEC Pharmacy

Edexcel is recruiting external verifiers for its BTEC Certificate in Pharmacy Services. It is looking for pharmacy specialists with BTEC teaching experience who are interested in training for the EV role.

Joining Edexcel's Assessment Associate community as an external verifier offers an opportunity to develop insight into the assessment of vocational qualifications. You will benefit from ongoing training and expert support, and the experience you gain can enhance your professional development.

If you are retired, working as an EV can keep you in touch with your subject and provide continued job satisfaction. In addition to fees and expenses, EVs receive a comprehensive rewards package.

If you are looking for a challenge, an opportunity to help improve student attainment or continued professional development visit www.edexcel.org.uk/as-recruitment to apply and to view details of the EV role.

34th UKMI Practice Development Seminar

The above conference was held at Warwick University from September 18-19. The programme included five plenary sessions covering Health Service reform, approving new drugs, hospital acquired infection, IT development in MI, patient safety issues and MI. In addition, a good range of parallel sessions covered a wide range of topics, all of which made the programme appealing both in terms of the speciality of MI and key issues in the NHS and profession.

The College was represented by Ron Pate (CPP governor) and Helene Williams (CPP office manager). Ron chaired the plenary session titled "Approving New Drugs" and Helene promoted the College via the College stand in the exhibition area.

The plenary session included a presentation from Professor Andrew Stevens (head of Department of Public Health & Epidemiology at Birmingham University) on "NICE and the national processes for approving of new drugs" and from Professor Chris Newdick (Professor of Health Law at the University of Reading) on "NHS resources and patients' rights – PCT processes for approving new drugs".

Ian Simpson: TransCom and beyond

College chief executive Ian Simpson was the keynote speaker at the BOPA Symposium in Liverpool on October 17. This is a summary of his address, which will also update College members on the work of the Transitional Committee (TransCom), of which he is a member

The Danish physicist and Nobel Prize Winner Niels Bohr (1885-1962) said: "Prediction is very difficult, especially about the future", and Lord Jenkins of Hillhead, the British politician and former Chancellor of the University of Oxford, said: "I have found the future rather difficult to predict before it happens."

Well perhaps the future of pharmacy is not so difficult to predict, because we have some factors which help us. These are:

- New therapies
- New technologies
- Public expectations
- Government policy
- New legislation
- Professional aspirations.

New therapies and new technologies have been covered adequately in the Pharmacy 2020 session at BPC 2008, and are also being addressed in the BOPA Symposium 2008, so I will concentrate on the other items.

Public expectations have been elegantly summed up by Nigel Clarke. In his introduction to the Clarke Inquiry (2008), he said: "Patients and the wider public, driven by a more consumerist society and significant technological advances, expect a great deal from those who offer them care. This is expressed in part in demands for safety and in part in expectations of constant improvements in standards of service."

In the light of these public expectations, the Government has published a plethora of policies in the last 18 months. This includes:

- Trust, Assurance and Safety – the regulation of health professionals in the 21st century.
- Report of the Working Party on Professional Regulation and Leadership in Pharmacy.
- Pharmacy in England: building on strengths – delivering the future.
- Remedies for success: A strategy for pharmacy in Wales.
- Better Health, Better Care.

The main points about pharmacy in Trust Assurance and Safety were:

- The Royal Pharmaceutical Society's dual role as regulator and professional body is no longer tenable.
- The Government intends to establish a General Pharmaceutical Council to regulate pharmacists, pharmacy technicians and pharmacy premises.
- There will need to be a strong professional body for pharmacy to take on a role akin to that of a Royal College.

We have a golden opportunity to establish a new professional body to which all of us will be proud to belong

Following on from this White Paper, the Government introduced new legislation in the Health and Social Care Act 2008, which will allow it to establish the General Pharmaceutical Council. It also established the Pharmacy Regulation and Leadership Oversight Group (PRLOG) to oversee the process.

In parallel with this, the profession has introduced a number of initiatives to take forward the process of establishing a new professional body. These include:

- The King's Fund Seminar
- The Waterloo Agreement
- Forward from Waterloo
- The Clarke Inquiry set up by the Royal Pharmaceutical Society
- The Transitional Committee (TransCom)

TransCom is chaired by Nigel Clarke and consists of seven members who have been appointed by the Royal Pharmaceutical Society and eight appointed by the Chairman, on the recommendation of various pharmacy bodies. I am pleased to be a member, as the nominee of the College of Pharmacy Practice.

College chief executive Ian Simpson

The main aim of TransCom is to create a Prospectus for a new professional body (NPB) for pharmacy, which will cover:

- Structure
- Governance
- Membership categories
- Membership services offered
- Research function
- Arrangements for the development of practice for members
- Leadership of the profession

This is being done through an open arrangement involving:

- Working groups/Sub-committees
- Holding meetings and calling for submissions from the profession
- The TransCom website – www.transitionalcommittee.com

In order to carry out its work, TransCom has established a number of Working Groups and Sub-Committees, each chaired by one of the members. I have been chairing the Working Group on Improved, Advanced and Specialist Practice, and am pleased to have Graeme Hall, Professional Secretary of UKCPA as my Vice-Chairman.

In relation to practice, The IASP Working Group has proposed a model that will provide universal local access for practitioners to a set of professional curricula, with:

- Support for career and competence development.
- Support for revalidation and regulation.
- An incentive to join a new professional body.
- A raison d'être for a new professional body.

This will be delivered through a structure consisting of:

- A General Board
- A Specialist Board
- A series of Local Programme Boards

The NPB will work with special interest groups affiliated to, hosted by or converged with it to provide a standard framework for validation of advanced and specialist practice, and to inform and support general level practice.

TransCom worked to a very tight timetable to have the Prospectus finalised by the end of October, for presentation to the Society's Council on November 6. The Prospectus has been approved for publication and will be circulated to all RPSGB members on November 28.

What will this mean for you?

- You will have to register with the GPhC when it is established in 2010
- If you do not register, you will not have the right to call yourself a pharmacist or pharmacy technician.
- Registration will probably not carry the right to post-nominal letters.
- You may also wish to join the new professional body
- This will carry the right to post-nominal letters.

What can you do now?

- Visit the TransCom website.
- Comment on the papers.
- Write a blog.
- Let your specialist organisation (CPP, BOPA, FPMM, FNPP, FCP, APTUK) know your views on its future. Should it be affiliated to, hosted by or converged with the NPB?
- Read the Prospectus and comment on it.
- Respond to the RPSGB consultation on the Charter.
- Vote in the RPSGB ballot on the Special Resolution.

The challenge for us all

We have a golden opportunity to establish a new professional body to which all of us will be proud to belong.

This is your opportunity to play your part in deciding the future of your profession.

TransCom has made the following recommendations on membership of the new professional body:

Membership of the NPB will be open to:

- Practising pharmacists
- Non-practising pharmacists
- Retired pharmacists

There will also be:

- Student* members – those undertaking a pharmacy or pharmaceutical sciences degree or other specifically pharmacy-related degree
- Pre-reg* members
- International members – those regulated by an overseas regulator or who are members of a professional body in another country
- Pharmaceutical scientist* members – those qualified to degree level in pharmaceutical sciences working within professions allied to pharmacy

* Please note these are working titles and not confirmed. Other organisations may be affiliated to the NPB (e.g. APTUK)

CPP News

NOVEMBER 2008

The Pharmacy Show 2008

Office manager Helene Williams chats with College Member Emeritus Peter Homan

As in previous years, the College had a stand at the Pharmacy Show, which was held at the NEC from October 12-13.

The stand was manned by office manager Helene Williams, who received enquiries from a number of students from Bradford and Aston Universities. Other visitors on Sunday were mainly community pharmacists, while Monday's visitors were mostly from the commercial and industrial sectors.

Seminars were held on both days, and these were accredited by the College. Sunday's speakers were provided by IPF, and Monday's by the English Pharmacy Board. Fin McCaul, chairman of IPF, opened and closed the seminars on Sunday.

Sunday's speakers and topics were as follows:

- Dr Keith Ridge, Chief Pharmacist: "Community Pharmacy 2009-2012"
- John Davies, Mawdsley's: "Cash Flow and Survival Now"
- John D'Arcy, MD, Numark: "Community Pharmacist – Clinician or Retailer?"
- Mike King, Head of Contractor Support, PSNC: "New Funding or New Labels"
- Paul Bennett, Chair, NPA: "Community Pharmacist – Clinical Service Provider"
- Andy Murdock, Lloydspharmacy: "Profit is not a Dirty Word"

Monday's speakers and topics:

- Lindsey Gilpin and Jonathan Buisson, EPB: "The EPB – A Step Ahead of the Game"
- Sultan Dajani, EPB: "The EPB – All Views, All Sides, Always"

Pharma Awards 2008

Sixteen individuals and teams from the pharmacy world scooped national awards at the Pharma Awards Gala Dinner and Presentation ceremony. The event was hosted by Pioneer Global Media on Sunday October 12 at the Hilton Metropole, Birmingham, and it was hailed by sponsor Pfizer as "a collaborative forum and opportunity to recognise and reward the achievers of our profession".

The College is proud to announce that, among the Award winners was College associate governor Mel Smith, who was awarded Industrial Pharmacist of the Year.

The judges commented: "Melvyn has represented industrial pharmacists as the chairman of the Industrial Pharmacist Group, associate governor at the College of Pharmacy Practice, director of the Institute of Pharmacy Management and chairman of the Local Branch. Melvyn is keen in enabling other pharmacists to develop their own skills. He worked with Nottingham University on the development of computer aided learning packages, which allowed pharmacy students and pharmacists to test their own knowledge of areas of treatment. Using the skills has learnt within the pharmaceutical industry, he developed a series of booklets designed to allow community pharmacist to improve their management skills."


College associate governor Mel Smith, winner of the Industrial Pharmacist of the Year Award

Trevor Gore of Reckitt Benckiser accepted the award on behalf of Mel, who was unable to attend the event.

IMPORTANT CLINICAL INFORMATION

Dear Pharmacist,

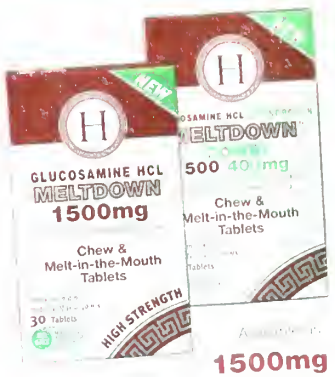
To assist your professional response please see below details of our National Media Advertising Campaign, alerting HYPERTENSIVE Patients to potential Potassium Supplement interactions with their medication.

Taking Glucosamine with blood-pressure tablets?

A **newer, purer, chewable** form of Glucosamine ***just for you***

Potassium Chloride Salt-Free

Some Healthcare Professionals are suggesting a switch to a newer, purer, form of Glucosamine for Patients who also take blood-pressure tablets.



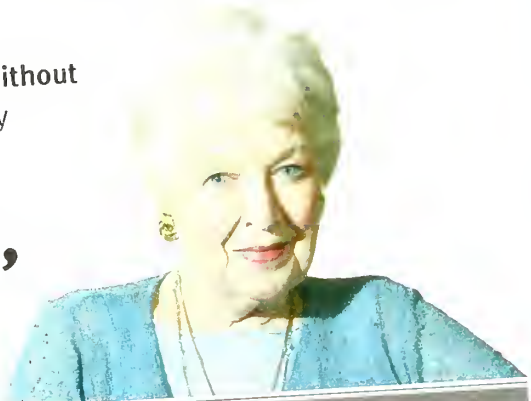
1500mg
750mg
500mg
Combi 500/400mg

- Your current Glucosamine product is Glucosamine **SULPHATE 2KCL** (which contains added **Potassium Salt** – known as **KCL**).
- **Potassium Salt (KCL)** can potentially react with some blood-pressure tablets, known to Doctors as:
  - ACE Inhibitors (label name ends in "...PRIL")
  - Angiotensin II Antagonists (label name ends in "...SARTAN")
  - Potassium Sparing Diuretics

  (Please Check Your Labels)
- ***NEW*** Glucosamine **Meltdown**™ contains no **Potassium Salt** so may be taken with these blood-pressure tablets.
- ***NEW*** Glucosamine **Meltdown**™ comes as a once-a-day, orange-flavoured, chewable tablet which is easy to swallow.
- ***NEW*** Glucosamine **Meltdown**™ is available **without Prescription** from your LOCAL PHARMACY by request.

JUNE WHITFIELD

"A GOOD CHOICE"



For further information

www.meltdownglucosamine.com

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CUT OUT AND TAKE TO YOUR LOCAL PHARMACY FOR ADVICE

Medical Department
DALLAS BURSTON HEALTHCARE

SUPPORTING LOCAL PHARMACY

C+D Update 2009... C+D Update 2009...

CPD for under £25*

To give your patients the maximum benefit of your expertise, you need to continually update your knowledge. In addition, as mandatory CPD for practising pharmacists draws closer, it's time to think about your continuing education for 2009.

Why not register with the leading weekly magazine for pharmacists?

- Gain access to over 40 modules which can be included in your RPSGB Plan and Record portfolio.
- Straightforward self-test questions and evidence of completion
- *Register before January 31 and save £5 off the normal fee of £32.50. Even better, why not register yourself and a colleague and save yourself £10! All applications received by January 31 will be entered into a prize draw for an iPod touch.

Visit www.chemistanddruggist.co.uk/update to find out more

PLUS be in with a chance of winning an iPod Touch

Supported by

GENUS PHARMACEUTICALS

- **Register by phone (card payment only) Call 01732 377269**
- **Register by post (card payment or cheque) Use the coupon below and return to: Pharmacy Projects, Riverbank House, Angel Lane, Tonbridge, Kent, TN9 1SE**

CUT HERE IF NECESSARY

Pharmacy Update 2009 registration form

Please register me for Pharmacy Update in 2009.

❑ I enclose a cheque payable to CMP Information for £27.50

❑ Please charge £27.50 to my credit/debit card

❑ I am enrolling a colleague (form enclosed). I enclose a cheque for £22.00/charge my credit/debit card £22.00

Card Payment Details

Card type: Credit ❑ Visa ❑ Mastercard ❑ Debit ❑

Maestro ❑ Other (please state) _____

Card No: _____

Expiry date: _____ Issue No (debit cards): _____

❑ I wish to use the telephone assessment service

❑ I wish to use the online assessment service*

*Please note in order to use this service you will be registered on the C+D website which will also provide you with email newsletters. You must provide an email address to use this service.

Name:

Address:

Postcode:

Date:

Signature:

Daytime phone number:

(No payment will be accepted without a phone number)

Email address:

❑ Please tick this box if you would like to find out about similar products and services for healthcare professionals from CMPMedica. Our emails may also include information from other carefully selected companies that may be of interest to you. Your personal details WILL NOT be passed on to any third party without your consent

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Pharmacyupdate

distance learning for pharmacists and technicians

November 2008

To give your patients the maximum benefit of your expertise, you need to review and continually update your knowledge. The Pharmacy Update modular course has been devised to provide you with an effective and enjoyable way to do this.
You can test your increased understanding of topics covered in November's Pharmacy Update by answering the questions below. Those pharmacists and pharmacy technicians who wish to register their answers may phone our telephone marking service on 08705 800281 (see overleaf for details). Pharmacists and technicians who register will automatically be provided with a module completion certificate, which may be presented to primary care organisations and other bodies as independent verification of the amount of CPP-accredited continuing education you have undertaken, as part of your continuing professional development.
The questions below relate to modules carried in November's Pharmacy Update.

- Pregnancy problems (module 1455) – November 8
- Childhood infections (module 1456) – November 15
- Epilepsy treatments (module 1457) – November 29

Correctly answering 80 per cent of all questions is sufficient to achieve three hours' continuing education credit. Alternatively, each module can be answered individually, with an 80 per cent pass rate leading to the indicated units of continuing education credit.
Only tick the boxes which are correct statements or answers.

Module 1455

Pregnancy problems

1. Increased oestrogen levels may be a cause of constipation in pregnancy. True ☐1 False ☐0

2. Early in pregnancy a woman may need to urinate more frequently because of increased blood flow through the kidneys. True ☐1 False ☐0

3. Alginates should be avoided in pregnancy because their sodium content may increase blood pressure. True ☐1 False ☐0

4. Nausea in pregnancy resolves by the 16th week in most women. True ☐1 False ☐0

5. Omeprazole can be recommended for heartburn in the third trimester of pregnancy. True ☐1 False ☐0

6. Progesterone can contribute to an increase in hair condition and thickness in pregnancy. True ☐1 False ☐0

7. Which of the following could be recommended safely for a pregnant woman?
a) Dextromethorphan ☐
b) Chloramphenicol ☐
c) Podophyllum ☐
d) Salicylic acid ☐

Module 1456

Childhood diseases

1. Human normal immunoglobulin, if given within 72 hours of exposure, can reduce the severity of measles. True ☐1 False ☐0

2. The incubation period for chicken pox is one to two weeks. True ☐1 False ☐0

3. If a woman has chicken pox while pregnant, the greatest risk to the unborn child is between three and five months of pregnancy. True ☐1 False ☐0

4. Mumps has an incubation period of seven to 21 days. True ☐1 False ☐0

5. A child with whooping cough is infectious for four days before and until 14 days after the cough started. True ☐1 False ☐0

6. Bacterial meningitis is more common than viral, which is less serious. True ☐1 False ☐0

7. Which of the following statements is true? Whooping cough has an incubation period of:
a) Two to five days ☐
b) Five to 14 days ☐
c) 10-14 days ☐
d) 14-21 days ☐

Module 1457

Epilepsy treatments

1. The maximum dose of clobazam is 60mg daily. True ☐1 False ☐0

2. The usual maintenance dose of tiagabine when taken with enzyme-inducing drugs is 15-30mg. True ☐1 False ☐0

3. The drug of choice for treating myoclonic seizures is lamotrigine. True ☐1 False ☐0

4. Young children need proportionally higher doses of anti-epileptic drugs than adults. True ☐1 False ☐0

5. All anti-epileptic drugs need close monitoring of plasma blood levels to assist dosing adjustments. True ☐1 False ☐0

6. Ketogenic diets may be helpful in reducing seizures in adults and children. True ☐1 False ☐0

7. Which of the following is used to treat epilepsy triggered by menstruation?
a) Lamotrigine ☐
b) Acetazolamide ☐
c) Gabapentin ☐
d) Topiramate ☐

Please turn over to find out how to register for telephone marking

C+D PHARMACYupdate: information on registration

To register for telephone marking there is an administration fee of £32.50 (inc. VAT). Please send your cheque (total £32.50 inc. VAT), made payable to CMP Information Ltd, to Pharmacy Projects, CMP Information, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE. On receipt of your cheque, you will be issued with a personal identification number (PIN) valid for all CPP-accredited Pharmacy Update Modules carried in C+D in 2008.

To use the telephone marking service you will need access to a touch tone telephone. The service is interactive – listen to the instructions and press buttons 1 to 4 to indicate your answer. Please note calls are charged at standard national rates, NOT premium rates.

Module completion letters will be sent to registered pharmacists and technicians twice a year, indicating which Update Modules have been undertaken in each half year. Letters will be dispatched in August 2008 and February 2009. The number of hours of accredited continuing education per month will vary, but over the year will be a minimum of 30 hours.

Accredited Pharmacy Update Modules and MCQs are available on the C+D website, www.chemistanddruggist.co.uk/update

These three distance learning Modules, consisting of three articles and this question paper, have been registered with the College of Pharmacy Practice as each providing one unit of postgraduate education towards the College's continuing education requirement. C+D Pharmacy Update Modules are, where indicated, accredited by the College of Pharmacy Practice.

Change of VAT rate

The December C+D Price List contains prices based on the old VAT rate of 17.5%. We do not intend to issue a revision to the December List — the revised prices will be shown in the January Price List published on December 20.

Any changes to prices notified to you in the weekly supplement this week (dated November 29) **do not** reflect the new VAT rates. All supplements issued from now on (electronic on December 6 and printed on December 13) will reflect the new VAT rates which come into effect on December 1.

Any price supplied in December by C+D will be calculated using the new VAT rate of 15% and will not reflect a manufacturer s suggested price. When a manufacturer notifies C+D Data of a change in a suggested price this will be notified to you as a price change in the normal way.

The C+D Data web site at **www.cddata.co.uk** will show prices that have been calculated using the new 15% VAT rate from Monday December 1. Please use your user name and password details on the wrapper of this mailing to access the site.

A Ready Reckoner is supplied on the reverse of this letter. Those wishing to use a calculator can use the following approximated formulae:

Take the old price and divide by 1.0217
Or
Take the old price and multiply by 0.9787

Please remember that as from January 2009 the C+D Price List Weekly Supplements will only be available electronically.

To make sure you continue to get your weekly updates, email your name,subscriber number and the email address to which you would like the updatesent, to:
priceupdates@chemistanddruggist.co.uk
or alternatively fill in this coupon.

❑ **Yes, I would like to receive weekly price updates from 2009 by email**

Select either
❑ **Weekly email with a link to the data**
or
❑ **Weekly email with PDF attachment**

Name
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Subscriber number
(found on the outside of C+D wrapper)

Please return to: Emily Miles, Chemist+Druggist, CMP Medica, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

VAT Ready Reckoner

Old	New	Old	New	Old	New	Old	New	Old	New	Old	New
£0 01	£0 01	£1 01	£0 99	£2 01	£1 97	£3 05	£2 99	£8 05	£7 88	£13 05	£12 77
£0 02	£0 02	£1 02	£1 00	£2 02	£1 98	£3 10	£3 03	£8 10	£7 93	£13 10	£12 82
£0 03	£0 03	£1 03	£1 01	£2 03	£1 99	£3 15	£3 08	£8 15	£7 98	£13 15	£12 87
£0 04	£0 04	£1 04	£1 02	£2 04	£2 00	£3 20	£3 13	£8 20	£8 03	£13 20	£12 92
£0 05	£0 05	£1 05	£1 03	£2 05	£2 01	£3 25	£3 18	£8 25	£8 07	£13 25	£12 97
£0 06	£0 06	£1 06	£1 04	£2 06	£2 02	£3 30	£3 23	£8 30	£8 12	£13 30	£13 02
£0 07	£0 07	£1 07	£1 05	£2 07	£2 03	£3 35	£3 28	£8 35	£8 17	£13 35	£13 07
£0 08	£0 08	£1 08	£1 06	£2 08	£2 04	£3 40	£3 33	£8 40	£8 22	£13 40	£13 11
£0 09	£0 09	£1 09	£1 07	£2 09	£2 05	£3 45	£3 38	£8 45	£8 27	£13 45	£13 16
£0 10	£0 10	£1 10	£1 08	£2 10	£2 06	£3 50	£3 43	£8 50	£8 32	£13 50	£13 21
£0 11	£0 11	£1 11	£1 09	£2 11	£2 07	£3 55	£3 47	£8 55	£8 37	£13 55	£13 26
£0 12	£0 12	£1 12	£1 10	£2 12	£2 07	£3 60	£3 52	£8 60	£8 42	£13 60	£13 31
£0 13	£0 13	£1 13	£1 11	£2 13	£2 08	£3 65	£3 57	£8 65	£8 47	£13 65	£13 36
£0 14	£0 14	£1 14	£1 12	£2 14	£2 09	£3 70	£3 62	£8 70	£8 51	£13 70	£13 41
£0 15	£0 15	£1 15	£1 13	£2 15	£2 10	£3 75	£3 67	£8 75	£8 56	£13 75	£13 46
£0 16	£0 16	£1 16	£1 14	£2 16	£2 11	£3 80	£3 72	£8 80	£8 61	£13 80	£13 51
£0 17	£0 17	£1 17	£1 15	£2 17	£2 12	£3 85	£3 77	£8 85	£8 66	£13 85	£13 56
£0 18	£0 18	£1 18	£1 15	£2 18	£2 13	£3 90	£3 82	£8 90	£8 71	£13 90	£13 60
£0 19	£0 19	£1 19	£1 16	£2 19	£2 14	£3 95	£3 87	£8 95	£8 76	£13 95	£13 65
£0 20	£0 20	£1 20	£1 17	£2 20	£2 15	£4 00	£3 91	£9 00	£8 81	£14 00	£13 70
£0 21	£0 21	£1 21	£1 18	£2 21	£2 16	£4 05	£3 96	£9 05	£8 86	£14 05	£13 75
£0 22	£0 22	£1 22	£1 19	£2 22	£2 17	£4 10	£4 01	£9 10	£8 91	£14 10	£13 80
£0 23	£0 23	£1 23	£1 20	£2 23	£2 18	£4 15	£4 06	£9 15	£8 96	£14 15	£13 85
£0 24	£0 23	£1 24	£1 21	£2 24	£2 19	£4 20	£4 11	£9 20	£9 00	£14 20	£13 90
£0 25	£0 24	£1 25	£1 22	£2 25	£2 20	£4 25	£4 16	£9 25	£9 05	£14 25	£13 95
£0 26	£0 25	£1 26	£1 23	£2 26	£2 21	£4 30	£4 21	£9 30	£9 10	£14 30	£14 00
£0 27	£0 26	£1 27	£1 24	£2 27	£2 22	£4 35	£4 26	£9 35	£9 15	£14 35	£14 04
£0 28	£0 27	£1 28	£1 25	£2 28	£2 23	£4 40	£4 31	£9 40	£9 20	£14 40	£14 09
£0 29	£0 28	£1 29	£1 26	£2 29	£2 24	£4 45	£4 36	£9 45	£9 25	£14 45	£14 14
£0 30	£0 29	£1 30	£1 27	£2 30	£2 25	£4 50	£4 40	£9 50	£9 30	£14 50	£14 19
£0 31	£0 30	£1 31	£1 28	£2 31	£2 26	£4 55	£4 45	£9 55	£9 35	£14 55	£14 24
£0 32	£0 31	£1 32	£1 29	£2 32	£2 27	£4 60	£4 50	£9 60	£9 40	£14 60	£14 29
£0 33	£0 32	£1 33	£1 30	£2 33	£2 28	£4 65	£4 55	£9 65	£9 44	£14 65	£14 34
£0 34	£0 33	£1 34	£1 31	£2 34	£2 29	£4 70	£4 60	£9 70	£9 49	£14 70	£14 39
£0 35	£0 34	£1 35	£1 32	£2 35	£2 30	£4 75	£4 65	£9 75	£9 54	£14 75	£14 44
£0 36	£0 35	£1 36	£1 33	£2 36	£2 31	£4 80	£4 70	£9 80	£9 59	£14 80	£14 49
£0 37	£0 36	£1 37	£1 34	£2 37	£2 32	£4 85	£4 75	£9 85	£9 64	£14 85	£14 53
£0 38	£0 37	£1 38	£1 35	£2 38	£2 33	£4 90	£4 80	£9 90	£9 69	£14 90	£14 58
£0 39	£0 38	£1 39	£1 36	£2 39	£2 34	£4 95	£4 84	£9 95	£9 74	£14 95	£14 63
£0 40	£0 39	£1 40	£1 37	£2 40	£2 35	£5 00	£4 89	£10 00	£9 79	£15 00	£14 68
£0 41	£0 40	£1 41	£1 38	£2 41	£2 36	£5 05	£4 94	£10 05	£9 84	£15 05	£14 73
£0 42	£0 41	£1 42	£1 39	£2 42	£2 37	£5 10	£4 99	£10 10	£9 89	£15 10	£14 78
£0 43	£0 42	£1 43	£1 40	£2 43	£2 38	£5 15	£5 04	£10 15	£9 93	£15 15	£14 83
£0 44	£0 43	£1 44	£1 41	£2 44	£2 39	£5 20	£5 09	£10 20	£9 98	£15 20	£14 88
£0 45	£0 44	£1 45	£1 42	£2 45	£2 40	£5 25	£5 14	£10 25	£10 03	£15 25	£14 93
£0 46	£0 45	£1 46	£1 43	£2 46	£2 41	£5 30	£5 19	£10 30	£10 08	£15 30	£14 97
£0 47	£0 46	£1 47	£1 44	£2 47	£2 42	£5 35	£5 24	£10 35	£10 13	£15 35	£15 02
£0 48	£0 47	£1 48	£1 45	£2 48	£2 43	£5 40	£5 29	£10 40	£10 18	£15 40	£15 07
£0 49	£0 48	£1 49	£1 46	£2 49	£2 44	£5 45	£5 33	£10 45	£10 23	£15 45	£15 12
£0 50	£0 49	£1 50	£1 47	£2 50	£2 45	£5 50	£5 38	£10 50	£10 28	£15 50	£15 17
£0 51	£0 50	£1 51	£1 48	£2 51	£2 46	£5 55	£5 43	£10 55	£10 33	£15 55	£15 22
£0 52	£0 51	£1 52	£1 49	£2 52	£2 47	£5 60	£5 48	£10 60	£10 37	£15 60	£15 27
£0 53	£0 52	£1 53	£1 50	£2 53	£2 48	£5 65	£5 53	£10 65	£10 42	£15 65	£15 32
£0 54	£0 53	£1 54	£1 51	£2 54	£2 49	£5 70	£5 58	£10 70	£10 47	£15 70	£15 37
£0 55	£0 54	£1 55	£1 52	£2 55	£2 50	£5 75	£5 63	£10 75	£10 52	£15 75	£15 41
£0 56	£0 55	£1 56	£1 53	£2 56	£2 51	£5 80	£5 68	£10 80	£10 57	£15 80	£15 46
£0 57	£0 56	£1 57	£1 54	£2 57	£2 52	£5 85	£5 73	£10 85	£10 62	£15 85	£15 51
£0 58	£0 57	£1 58	£1 55	£2 58	£2 53	£5 90	£5 77	£10 90	£10 67	£15 90	£15 56
£0 59	£0 58	£1 59	£1 56	£2 59	£2 53	£5 95	£5 82	£10 95	£10 72	£15 95	£15 61
£0 60	£0 59	£1 60	£1 57	£2 60	£2 54	£6 00	£5 87	£11 00	£10 77	£16 00	£15 66
£0 61	£0 60	£1 61	£1 58	£2 61	£2 55	£6 05	£5 92	£11 05	£10 81	£16 05	£15 71
£0 62	£0 61	£1 62	£1 59	£2 62	£2 56	£6 10	£5 97	£11 10	£10 86	£16 10	£15 76
£0 63	£0 62	£1 63	£1 60	£2 63	£2 57	£6 15	£6 02	£11 15	£10 91	£16 15	£15 81
£0 64	£0 63	£1 64	£1 61	£2 64	£2 58	£6 20	£6 07	£11 20	£10 96	£16 20	£15 86
£0 65	£0 64	£1 65	£1 61	£2 65	£2 59	£6 25	£6 12	£11 25	£11 01	£16 25	£15 90
£0 66	£0 65	£1 66	£1 62	£2 66	£2 60	£6 30	£6 17	£11 30	£11 06	£16 30	£15 95
£0 67	£0 66	£1 67	£1 63	£2 67	£2 61	£6 35	£6 21	£11 35	£11 11	£16 35	£16 00
£0 68	£0 67	£1 68	£1 64	£2 68	£2 62	£6 40	£6 26	£11 40	£11 16	£16 40	£16 05
£0 69	£0 68	£1 69	£1 65	£2 69	£2 63	£6 45	£6 31	£11 45	£11 21	£16 45	£16 10
£0 70	£0 69	£1 70	£1 66	£2 70	£2 64	£6 50	£6 36	£11 50	£11 26	£16 50	£16 15
£0 71	£0 69	£1 71	£1 67	£2 71	£2 65	£6 55	£6 41	£11 55	£11 30	£16 55	£16 20
£0 72	£0 70	£1 72	£1 68	£2 72	£2 66	£6 60	£6 46	£11 60	£11 35	£16 60	£16 25
£0 73	£0 71	£1 73	£1 69	£2 73	£2 67	£6 65	£6 51	£11 65	£11 40	£16 65	£16 30
£0 74	£0 72	£1 74	£1 70	£2 74	£2 68	£6 70	£6 56	£11 70	£11 45	£16 70	£16 34
£0 75	£0 73	£1 75	£1 71	£2 75	£2 69	£6 75	£6 61	£11 75	£11 50	£16 75	£16 39
£0 76	£0 74	£1 76	£1 72	£2 76	£2 70	£6 80	£6 66	£11 80	£11 55	£16 80	£16 44
£0 77	£0 75	£1 77	£1 73	£2 77	£2 71	£6 85	£6 70	£11 85	£11 60	£16 85	£16 49
£0 78	£0 76	£1 78	£1 74	£2 78	£2 72	£6 90	£6 75	£11 90	£11 65	£16 90	£16 54
£0 79	£0 77	£1 79	£1 75	£2 79	£2 73	£6 95	£6 80	£11 95	£11 70	£16 95	£16 59
£0 80	£0 78	£1 80	£1 76	£2 80	£2 74	£7 00	£6 85	£12 00	£11 74	£17 00	£16 64
£0 81	£0 79	£1 81	£1 77	£2 81	£2 75	£7 05	£6 90	£12 05	£11 79	£17 05	£16 69
£0 82	£0 80	£1 82	£1 78	£2 82	£2 76	£7 10	£6 95	£12 10	£11 84	£17 10	£16 74
£0 83	£0 81	£1 83	£1 79	£2 83	£2 77	£7 15	£7 00	£12 15	£11 89	£17 15	£16 79
£0 84	£0 82	£1 84	£1 80	£2 84	£2 78	£7 20	£7 05	£12 20	£11 94	£17 20	£16 83
£0 85	£0 83	£1 85	£1 81	£2 85	£2 79	£7 25	£7 10	£12 25	£11 99	£17 25	£16 88
£0 86	£0 84	£1 86	£1 82	£2 86	£2 80	£7 30	£7 14	£12 30	£12 04	£17 30	£16 93
£0 87	£0 85	£1 87	£1 83	£2 87	£2 81	£7 35	£7 19	£12 35	£12 09	£17 35	£16 98
£0 88	£0 86	£1 88	£1 84	£2 88	£2 82	£7 40	£7 24	£12 40	£12 14	£17 40	£17 03
£0 89	£0 87	£1 89	£1 85	£2 89	£2 83	£7 45	£7 29	£12 45	£12 19	£17 45	£17 08
£0 90	£0 88	£1 90	£1 86	£2 90	£2 84	£7 50	£7 34	£12 50	£12 23	£17 50	£17 13
£0 91	£0 89	£1 91	£1 87	£2 91	£2 85	£7 55	£7 39	£12 55	£12 28	£17 55	£17 18
£0 92	£0 90	£1 92	£1 88	£2 92	£2 86	£7 60	£7 44	£12 60	£12 33	£17 60	£17 23
£0 93	£0 91	£1 93	£1 89	£2 93	£2 87	£7 65	£7 49	£12 65	£12 38	£17 65	£17 27
£0 94	£0 92	£1 94	£1 90	£2 94	£2 88	£7 70	£7 54	£12 70	£12 43	£17 70	£17 32
£0 95	£0 93	£1 95	£1 91	£2 95	£2 89	£7 75	£7 59	£12 75	£12 48	£17 75	£17 37
£0 96	£0 94	£1 96	£1 92	£2 96	£2 90	£7 80	£7 63	£12 80	£12 53	£17 80	£17 42
£0 97	£0 95	£1 97	£1 93	£2 97	£2 91	£7 85	£7 68	£12 85	£12 58	£17 85	£17 47
£0 98	£0 96	£1 98	£1 94	£2 98	£2 92	£7 90	£7 73	£12 90	£12 63	£17 90	£17 52
£0 99	£0 97	£1 99	£1 95	£2 99	£2 93	£7 95	£7 78	£12 95	£12 67	£17 95	£17 57
£1 00	£0 98	£2 00	£1 96	£3 00	£2 94	£8 00	£7 83	£13 00	£12 72	£18 00	£17 62

To calculate the change take the old price and divide by 1.0217 or take the old price and multiply by 0.9787

TABLE 2: BNF RECOMMENDATIONS ON THE CHOICE OF AED[2]

Seizure type	First choice	Alternatives/second-line drugs
Tonic-clonic (grand mal)	Carbamazepine, lamotrigine, sodium valproate or topiramate	Clobazam, levetiracetam and oxcarbazepine
Absence (petit mal)	Ethosuximide or sodium valproate	Clonazepam and lamotrigine
Myoclonic	Sodium valproate	Clonazepam, levetiracetam, lamotrigine and topiramate
Atypical absence, atonic and tonic seizures	Patients tend to respond poorly to traditional drugs, but sodium valproate, lamotrigine and clonazepam can be tried	Clobazam, ethosuximide, levetiracetam and topiramate.
Partial (focal) seizures	Carbamazepine, lamotrigine, oxcarbazepine, sodium valproate or topiramate	Clobazam, gabapentin, levetiracetam, pregabalin, tiagabine and zonisamide

prove effective, especially when coupled with lifestyle advice to reduce the risk of seizures. Some patients find that complementary therapy can help when used as an adjunct to AEDs. Options include acupuncture, aromatherapy, biofeedback, herbals and homeopathy. Ketogenic diets may benefit children not responding well to other forms of treatment but are not recommended for adults because of the raised risk of other serious conditions such as hypertension and heart disease. Important lifestyle advice includes keeping a seizure diary to identify and avoid trigger factors. Everyday factors that may push a patient over their seizure threshold include:

- alcohol and recreational drugs
- late nights and lack of sleep
- stress
- missing an AED dose
- flickering or flashing lights
- illness
- hormones
- food
- certain medications or supplements.

In addition, evening primrose oil may increase the likelihood of seizures, and St John's wort is known to interact with certain AEDs.

For poorly controlled epilepsy, vagus nerve stimulation (VNS) is a potential non-drug approach. A small electrical device is surgically implanted under the skin near the collar bone, with a lead wrapped around the vagus nerve itself. Regular passage of electricity stimulates the nerve, reducing the frequency and severity of seizures. For more severe or treatment-refractory cases, brain surgery is an option.

Your Continuing Professional Development

CPD

Act

- Read the MUR tips on effective epilepsy management in the MUR Zone of C+D's website (www.chemistanddruggist.co.uk).
- Read the Pharmacy Update article on Epilepsy in last week's C+D if you have not already done so.
- Read section 4.8.1 Control of epilepsy in the BNF for more information about the interactions between anti-epileptic drugs.
- There is detailed information about the treatment of epilepsy with a ketogenic diet on the Epilepsy Action website www.epilepsy.org.uk/info/ketogenic.html. What advice could you give to a parent asking about this? Are there any resources you could recommend?
- People with epilepsy may want to try complementary therapies to help with their condition. Find out about therapies that could be helpful. The National Society for Epilepsy has some information at http://tinyurl.com/2coyzg.
- To find more about vagus nerve stimulation read the information on the Epilepsy Action website, which gives details of this treatment and its side effects www.epilepsy.org.uk/info/vagal html.
- More information about the Epilepsy Aware campaign by Epilepsy Action can be found at www.epilepsy.org.uk/node/300. Is this something you could consider joining?

Evaluate

- Are you now familiar with the drugs used in the treatment of epilepsy, their doses, side effects and interactions? Are you able to counsel people taking these medications about problems they may have with compliance?

The pharmacist's role

Adherence to anti-epileptic medication is key to success and pharmacists have an important role in emphasising and encouraging compliance. In particular, it is vital that anti-epileptics are withdrawn only under careful specialist supervision, with gradual reductions in dosage over several months. Patients should be made aware that abrupt withdrawal, particularly of barbiturates and benzodiazepines, must be avoided as this may precipitate severe rebound seizures. Even in patients who have been seizure-free for years there is a significant risk of recurrence if medication is suddenly stopped. Pharmacists can help patients stick to their AED regimen by:

- helping to develop cues for remembering when to take doses
- recommending compliance aids
- highlighting the potential consequences of non-compliance.

Pharmacists can maximise their role by signing up to Epilepsy Action's "Epilepsy Aware" campaign. The pharmacy is supplied with a window sticker showing it to be 'epilepsy friendly', signalling a commitment to:

- offer customers information on epilepsy and their medication
- discuss AED issues, including potential side effects, consistency of supply and drug interactions
- provide contact details for the epilepsy helpline and website.

When dispensing, pharmacists should be aware that switching from branded to generic AEDs can have serious consequences. An Epilepsy Action survey found that one-third of all patients were given a different version or brand of their regular AED and, of those, nearly a quarter experienced increased seizures as a result.[5]

A quarter of patients surveyed reported receiving 'mixed bundles' of different AEDs at any one time.[5] On the back of these findings, Epilepsy Action has urged healthcare professionals not to change ▶

Loss of disease control through AED non-compliance can lead to:[4]

- increased seizures
- more severe seizures
- convulsions
- raised risk of premature death
- revocation of driving licence
- impact on employment
- risk of injury
- hospitalisation
- impact on relationships
- cognitive impairment.

formulation or brand of AED until it is proven safe to do so.

For further information on the "Epilepsy Aware" campaign contact Gavin Barlow, Epilepsy Action Sapphire Nurse co-ordinator (tel: 0113 210 8800; email: gbarlow@epilepsy.org.uk)

Helen Boreham is a freelance medical and healthcare writer with an MSci degree in medicinal chemistry.

References
1. UK Anti-Epileptic Drugs List 2008. Published by Epilepsy Action.
2. British National Formulary (BNF) 55.
3. Neal, MJ. Medical Pharmacology at a Glance. 3rd Edition. Blackwell Science.
4. Schachter, SC. Consequences of Noncompliance. epilepsy.com
5. Epilepsy Action. Anti-Epileptic Medication Packaging Survey. October 2003.

Jolly Christmas binge or serious alcohol problem? Next week's Update is on alcohol abuse. The article will be available as a PDF and as a Podcast with our December 6 electronic edition. Go to: www.chemistanddruggist.co.uk

CPD Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the November 29 issue, which will cover this month's three CPP-accredited modules. A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on **01732 377269**.

Chemist+Druggist in association with Genus Pharmaceuticals

C+D

GENUS PHARMACEUTICALS

A Practical Approach — A co-amoxiclav question

The telephone rings at lunchtime in the dispensary of the Update Pharmacy.

Neither pharmacist David Spencer nor senior dispensing technician Brenda is available and trainee dispensing technician Yetunde answers.

The voice at the other end says: "Hello, it's Elaine Bennis here, the dentist from the practice round the corner. Could you do me a favour please? An NHS patient of mine has just phoned me; the amoxicillin I prescribed for her for a dental infection doesn't appear to be working and the infection is spreading. I think she needs co-amoxiclav. As it's urgent, I've told her to come to you straight away to pick up a supply. She says she gets all her prescriptions from you. Give her 15 tablets of 250/125 strength and tell her to take one every eight hours. I'll bring in the script myself tomorrow. Will that be OK?"

"I think so," says Yetunde, wanting to be helpful. "Give me the patient's details and I'll get the prescription ready. Mr Spencer will have to check it before we can give it out, but he'll be back in a few minutes."

When David returns, Yetunde shows him the labelled tablets and

the details she has taken from the dentist.

"I'm sorry," David says, "but we can't do this. But don't worry, I'll sort it out."

When David phones Elaine to explain, she is irritated and says: "I know it's not your fault David, but perhaps I should transfer my practice to Prague, or Helsinki or Zurich. I'd be all right then."

David arranges for the patient to receive the co-amoxiclav and the next morning David takes a call from the patient's husband.

"There's something wrong with those tablets," he says. "I've thrown them away."

When David asks why, he replies: "Soon after she took the first dose she went very strange for about an hour, like she was mad. She kept saying things like 'They're coming out of the television to get me. Can't you see them?' I was just about to call an ambulance when it passed and she's been fine since."

Questions
1. Why did the dentist want to prescribe co-amoxiclav?
2. Why could the tablets not be supplied?
3. How could David 'sort it out'?
4. What was the significance of the dentist's remark to David?
5. Could the co-amoxiclav have been the cause of the patient's strange behaviour?

This article can help in the following CPD competencies: **G1a, G1b, G1c, G1d, G1h, CG1s, G2o, C4b, C5a**
See http://tinyurl.com/68ox7b

C+D's A Practical Approach is supported by APOTEX UK LTD

Answers

1. Co-amoxiclav is effective against beta-lactamase-producing bacteria and is indicated for severe dental infection with spreading cellulitis if antibacterials without clavulanic acid have been ineffective (BNF, section 5.1.1).
2. For two reasons: co-amoxiclav is not included in the Dental Practitioners' Formulary, and UK registered dentists cannot authorise emergency supplies.
3. Liaise between the patient's GP and the dentist for the GP to authorise an emergency supply.
4. Since November, dentists registered in a country within the EU and Switzerland can authorise emergency supplies in the UK. UK dentists cannot do so until UK legislation has been amended.
5. Yes. A report has been published (BMJ 2008;337:a2117) of an acute psychotic episode following a single oral dose of co-amoxiclav 250/125.

Nice asks to restart anti-TNF appraisal

Nice is to ask the Department of Health whether it needs special permission to re-start its appraisal on sequential use of anti-TNF treatments for rheumatoid arthritis.

The health technology appraisal agency's appeals committee has decided to overturn an existing draft guidance that would have prevented patients who failed to respond to one anti-TNF from being treated with another from the same class.

This was despite evidence showing that patients who do not respond to one anti-TNF drug still have a significant chance of responding to another.

The committee decided that elements of the existing draft had been unfair, had failed to take account of costs such as replacement joints, and had not included the fact that patients with rheumatoid arthritis who are sero-negative do not respond as well to the monoclonal antibody treatment rituximab as those who are sero-positive.

Wyeth, which manufactures the anti-TNF etanercept, and was one of several companies and groups that appealed for the guidance to be reconsidered, said that Nice's decision to overturn its proposed recommendation was right.

"The practice of switching to a different drug after failure of another is standard clinical practice in all therapy areas," argued company medical director Dr Vignesh Rajah.

http://tinyurl.com/6lz3et

Clinical Briefs

SIGN headache guidance

Guidelines on the diagnosis and management of headache in adults have been issued by the Scottish Intercollegiate Guidelines Network. The document is intended to clarify the 'red flags' that warn of sinister conditions, and ensure appropriate treatment.
http://tinyurl.com/64o5d7

Rifampicin for TB

Four months of rifampicin treatment in latent tuberculosis leads to fewer serious adverse events and better adherence than nine months of isoniazid.
http://tinyurl.com/6nmzca

Asthma and COPD retests

British Lung Foundation charity officials have called for everyone over 35 with asthma or COPD to be retested following new evidence of misdiagnosis. In a survey of 776 GPs, 80 per cent said they found distinguishing between the diseases either quite difficult or very challenging.
http://tinyurl.com/6yuk8q

Clinical Alerts

SPC Changes

Ciproxin tablets 100mg, 250mg, 500mg, 750mg (ciprofloxacin) Changed indications based on resistance information and new guidance on dose adjustments in renal impairment. Bayer, 01635 563 000.

Oxis Turbohaler 12, Oxis Turbohaler 6 (formoterol inhalation powder) Not recommended for children under six due to lack of data. AstraZeneca UK, 01582 837 837, medical.informationuk@astrazeneca.com

Rebetol 200mg hard capsules, oral solution (ribavirin) New paragraph on ocular changes. Schering-Plough, 01707 363 636, medical.info@spcorp.com

Strattera 10mg, 18mg, 25mg, 40mg, 60mg, 80mg capsules (atomoxetine) Extensive changes. Eli Lilly and Co 01256 315 999, ukmedinfo@lilly.com

Zinacef (cefuroxime) Special warnings on renal impairment, vigilance for overgrowth of non-susceptible organisms, and on contraceptives. GlaxoSmithKline UK, 0800 221 441, customercontactuk@gsk.com
http://emc.medicines.org.uk

Supply issues

Visken 15mg 28s (pindolol) Out of stock until early 2009. Visken 5mg 56 tablets remain available. Amdipharm, 0870 7777675, medinfo@amdipharm.com

Spot-on blood glucose testing

TRUEone is a new blood glucose testing system available from Home Diagnostics. Test results are given in less than five seconds from a blood sample of 1 microlitre. The patient can choose forearm or fingertip testing.

Said to be the world's smallest all-in-one disposable blood glucose testing system, the TRUEone is designed to be small enough to fit in a pocket or bag to allow for testing anywhere at any time. It requires no coding, ensuring error-free results, says the company.

Available on the Drug Tariff, 50 strips are provided with a built-in meter.

DT price: £14.24
Pip code: 342-4389
Home Diagnostics
Tel: 0800 085 8808

Ahava skincare with a touch of velvet

Mineral Botanic is a new skin-nourishment range from Ahava. The velvet cream washes contain Dead Sea minerals, moisturising oils and organic plant extracts.

For normal to dry skin there are three options: orange and frangipani, grape and avocado or water lily and guarana. For very dry skin, customers can choose between the bamboo and pansy variant offering calming and age-delaying properties alongside moisturisation, and hibiscus and fig velvet, said to have antibacterial properties.

Two options for sensitive skin complete the line-up: honeysuckle and lavender, and lotus flower and chestnut.

Ahava says the new products' packaging is designed to convey the 'quality, efficacy and botanic ingredients' of the range. Support materials and point of sale displays are available.

Price: £15/500ml
Ahava UK
Tel: 01452 864574
Email: enquire@ahava.co.uk

Products in brief

Time for walkies

A pedometer for dogs is newly available in Lloydspharmacy. The gadget aims to help owners ensure their pets are getting enough exercise. It has two settings for large and small animals and is designed in the shape of a dog's face. It fits on the dog's collar and has a one-touch digital display. The pharmacy chain hopes the £3.50 gadget will appeal as a practical Christmas gift and help stave off diabetes, a condition an estimated one in 500 dogs will develop.

Boots battles SAD

Pharmacy chain Boots has reacted to the shortening days by introducing a range of clocks and lamps to help manage seasonal affective disorder (SAD). The 11 products in the range use light therapy to alleviate SAD symptoms.

• Boots has teamed up with girl band the Sugababes for its Christmas television advert this year. The ad shows an office scene with workers preparing 'secret Santa' presents.

SSL backs brands

Television advertising for Syndol begins this week, reports manufacturer SSL. The campaign forms part of a £1 million support package for the brand.

Both 10 and 30-second executions of the 'Added aaahh' creative will be seen, featuring a male office worker who strips off for a massage only to realise that the painkiller and a massage he was offered to ease his headache is actually what he will get from Syndol, not his attractive female boss. It is expected to appeal to the target audience of 24 to 45-year-old women, says SSL.

Meanwhile, SSL stablemate Medinol is being given new packaging to bring it in line with Medised. Late winter support will come in the form of above the line consumer activity, a 'word of mouth' marketing campaign, trade advertising and point of sale.

Product info:
SSL International
Tel: 0870 122 2689

Website wizardry

The Mentholatum website has been given a new design, said to be easy to navigate and offer clear product information. The designers were given a brief to make it as user-friendly as possible.

Included on the site is the history of the company and a product section where visitors can view the brands and find stockists. An 'ask our pharmacist' function enables surfers to pose questions about the products to Mentholatum's resident pharmacist.

Product info:
Mentholatum
Tel: 01355 848484
www.mentholatum.co.uk

Products advertised on TV next week

Bassetts Soft & Chewy vitamins: GMTV, Sat
Benylin Cold & Flu Day & Night Max Strength Capsules: All areas
Buttercup: GMTV, Sat, five
Covonia: GMTV, Sat, five
Gaviscon Double Action: All areas except GMTV, C4
Hedrin: GMTV, five, Sat
Just For Men: All areas
Nurofen Express: ITV, Sat
Seven Seas Cod Liver Oil & Joint Care: All areas
Syndol: GMTV
PharmaSite for next week: Thermacare – windows, **Thermacare** – in-store, **Tums** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Hyperiforce raises the mood

Hyperiforce is a new licensed remedy from A Vogel for the treatment of people feeling down, over-anxious or lacking in motivation. Made with organically grown Hypericum perforatum, dubbed the sunshine herb, the product is said to be a safe and effective traditional herbal treatment.

The product is backed up by the results of a trial of more than 200 patients carried out by A Vogel. After six weeks using the product, subjects reported an overall reduction in depressive symptoms of over 50 per cent. Low spirits improved by 54 per cent, anxiety by 53 per cent, nervousness by 50 per cent, insomnia by 52 per cent, fatigue by 57 per cent and headaches by 65 per cent.

Dosage is one tablet three times daily. The product is not recommended for use in the under 18s.

Price: £9.25/60
Pip code: 343-0584
Bioforce
Tel: 0800 085 0820

Oral probiotics strike a balance

The oral probiotic marketed as Gum PerioBalance by Sunstar has performed favourably in a study published by Acta Odontologica Scandinavica.

The trial involved 42 patients with moderate gingivitis given either chewing gum containing *Lactobacillus reuteri Prodentis* or placebo over two weeks.

The number of bleeding sites was reduced by 85 per cent among those chewing one piece of the active gum each day and fluid in the teeth pockets was decreased by 43 per cent. No significant changes were found in the controls.

Researcher Professor Svante Twetman comments: "The importance of this study is not only that it supports earlier findings that *L. reuteri Prodentis* can be effective in the treatment of gingivitis, but also that it points towards an extended mechanism of action beyond the ability of fighting off pathogens."

Product info:
Trinity Sales and Marketing
Tel: 01235 838 590

Make sure your transplant patients get the right brand of tacrolimus

- **ADVAGRAF®** is a **once-daily** prolonged-release formulation of tacrolimus, the same active ingredient found in **Prograf® (twice-daily tacrolimus)**
- **ADVAGRAF®** and **Prograf®** both have narrow therapeutic indices[1] requiring accurate blood levels of the drug to be maintained. The two brands are **not freely interchangeable**
- Under-dosing may increase the likelihood of graft rejection, and elevated blood levels are undesirable owing to the nephrotoxic potential of tacrolimus

It is important not to change formulation except on the advice of a transplant specialist (British National Formulary)[2]

ONCE DAILY DOSING

ADVAGRAF®
tacrolimus prolonged release

Prescribe by brand, Protect your patient

Reference: 1. Sabatini S et al AM J Kidney Dis 1999;**33**(2):389-397. **2.** British National Formulary September 2008.

Presentations: ADVAGRAF® Prolonged-release hard capsules containing tacrolimus 0.5 mg, 1 mg and 5 mg PRDGRAF® hard capsules containing tacrolimus 0.5 mg, 1 mg and 5 mg. **Indications:** ADVAGRAF® and PRDGRAF®: Prophylaxis of transplant rejection in adult liver or kidney allograft recipients and treatment of allograft rejection resistant to treatment with other immunosuppressive medicinal products. **Posology and Administration:** AOVAGRAF® and PRDGRAF® therapy require careful monitoring by adequately qualified and equipped personnel. Either drug should only be prescribed, and changes in immunosuppressive therapy initiated, by physicians experienced in immunosuppressive therapy and the management of transplant patients. Dosage recommendations given below should be used as a guideline. ADVAGRAF® or PRDGRAF® are routinely administered in conjunction with other immunosuppressive agents in the initial post-operative period. The dose may vary depending on the immunosuppressive regimen chosen. Dosing should be based on clinical assessments of rejection and tolerability aided by blood level monitoring. To suppress graft rejection immunosuppression must be maintained so no limit to the duration of oral therapy can be given. The daily dose of ADVAGRAF® capsules should be taken once daily in the morning with water at least 1 hour before or 2-3 hours after a meal. PRDGRAF® Capsules should be taken as for ADVAGRAF® in two divided doses. AOVAGRAF®: In stable patients converted from Prograf (twice daily) to ADVAGRAF® (once daily) on a 1:1 (mg·mg) total daily dose basis the systemic exposure to tacrolimus for ADVAGRAF® was approximately 10% lower than for Prograf. The relationship between tacrolimus trough levels (C24) and systemic exposure ($AUC_{0\text{-}24}$) for ADVAGRAF® is similar to that of Prograf. When converting from Prograf capsules to ADVAGRAF® trough levels should be measured before and within two weeks after conversion. In *de novo* kidney and liver transplant patients $AUC_{0\text{-}24}$ of tacrolimus for ADVAGRAF® on Day 1 was 30% and 50% lower respectively, when compared with that for PRDGRAF® at equivalent doses. By Day 4, systemic exposure as measured by trough levels is similar for both kidney and liver transplant patients with both formulations. Race: In comparison to Caucasians, Afro-Caribbean patients may require higher tacrolimus doses to achieve similar trough levels. Prophylaxis of transplant rejection - liver and kidney: Initial dose of AOVAGRAF® and PRDGRAF® Capsules is 0.10-0.20 mg/kg/day for liver transplantation and 0.20-0.30 mg/kg/day for kidney transplantation starting approximately 12 -18 hours for AOVAGRAF® and 12hrs for PRDGRAF® after completion of liver or within 24 hours of completion of kidney transplant surgery. Dose adjustment post-transplant: AOVAGRAF® and PRDGRAF® doses are usually reduced in the post-transplant period. It is possible in some cases to withdraw concomitant immunosuppressive therapy leading to ADVAGRAF® monotherapy or PRDGRAF® dual therapy or monotherapy. Post-transplant improvement in the condition of the patient may alter the pharmacokinetics of tacrolimus and may necessitate further dose adjustments. Dose recommendations - Conversion to ADVAGRAF®: Patients maintained on twice daily PRDGRAF® requiring conversion to once daily ADVAGRAF® should be converted on a 1:1 (mg·mg) total daily dose basis. Following conversion, tacrolimus trough levels should be monitored and if necessary dose adjustments made. Care should be taken when converting patients from ciclosporin-based to tacrolimus-based therapy. Initiate ADVAGRAF® after considering ciclosporin blood concentrations and clinical condition of patient. Delay dosing in presence of elevated ciclosporin blood levels. Monitor ciclosporin blood levels following conversion. Dose recommendations - Rejection therapy: For conversion of kidney and liver recipients from other immunosuppressants to once daily AOVAGRAF®, begin with the respective initial dose recommended for rejection prophylaxis. In adult heart transplant recipients converted to AOVAGRAF®, an initial oral dose of 0.15 mg/kg/day should be administered once daily in the morning. For other allografts, please see full SmPC. Dose adjustments in specific populations: Please see SmPC. Target whole blood trough concentration recommendations: Blood trough levels for ADVAGRAF® should be drawn approximately 24 hours post-dosing, just prior to the next dose, for PRDGRAF® approximately 12 hours post-dosing. Frequent trough level monitoring in the first two weeks post-transplant is recommended, with periodic monitoring during maintenance therapy. Monitoring is also recommended following conversion from PRDGRAF® to ADVAGRAF®, dose adjustment, changes in the immunosuppressive regimen, or co-administration of substances which may alter tacrolimus whole blood concentrations (see 'Warnings and Precautions' and 'Interactions'). Adjustments to the AOVAGRAF® and PRDGRAF® dose regimen may take several days before steady state is achieved. Most patients can be managed successfully if tacrolimus blood concentrations are maintained below 20 ng/mL. In clinical practice, whole blood trough levels have been 5-20 ng/mL in liver transplant recipients and 10-20 ng/mL in kidney transplant recipients early post-transplant, and 5-15 ng/mL during maintenance therapy. **Contraindications:** Hypersensitivity to tacrolimus or other macrolides or any excipient. **Warnings and Precautions:** ADVAGRAF® only limited experience in non-Caucasian patients and those at elevated immunological risk. ADVAGRAF® and PRDGRAF®: During initial period routinely monitor blood pressure, ECG, neurological and visual status, fasting blood glucose, electrolytes (particularly potassium), liver and renal function tests, haematology parameters, coagulation values, and plasma protein determinations; consider adjusting the immunosuppressive regimen if clinically relevant changes are seen. Herbal preparations, including those containing St. John's wort, should be avoided. Extra monitoring of tacrolimus concentrations is recommended during episodes of diarrhoea. Avoid concomitant administration of ciclosporin. Ventricular hypertrophy or hypertrophy of the septum (reported as cardiomyopathy) have been seen rarely. Other risk factors included pre-existing heart disease, corticosteroid usage, hypertension, renal or hepatic dysfunction, infections, fluid overload, and oedema. Echocardiography or ECG monitoring pre-and post-transplant is advised in high-risk patients, and dose reduction of and or a change of immunosuppressive agent should be considered if abnormalities develop. Tacrolimus may prolong the QT interval. Exercise caution in patients with diagnosed or suspected Congenital Long QT Syndrome. EBV-associated lymphoproliferative disorders have been reported. Concomitant use of other immunosuppressives such as antilymphocytic antibodies increases the risk of EBV-associated lymphoproliferative disorders. EBV-VCA negative patients have been reported to have increased risk of lymphoproliferative disorders; EBV-VCA serology should be ascertained before starting tacrolimus treatment. During treatment, careful monitoring with EBV-PCR is recommended. Exposure to sunlight and UV light should be limited. The risk of secondary cancer is unknown. Capsules contain lactose **Interactions:** See SMPC **Pregnancy and lactation:** Tacrolimus can be considered in pregnant women when there is no safer alternative. See SMPC. **Undesirable effects:** Many of the following adverse drug reactions are reversible and/or respond to dose reduction. Very Common (>1/10): Hyperglycaemic conditions, diabetes mellitus, hyperkalaemia, insomnia, tremor, headache, hypertension, diarrhoea, nausea, renal impairment. Common (>1/100 to <1/10): anaemia, leukopenia, thrombocytopenia, leukocytosis, red blood cell analyses abnormal, hypomagnesaemia, hypophosphataemia, hypokalaemia, hypocalcaemia, hyponatraemia, fluid overload, hyperuricaemia, appetite decreased, anorexia, metabolic acidoses, hyperlipidaemia, hypercholesterolaemia, hypertriglyceridaemia, anxiety symptoms, confusion and disorientation, depression, mood disorders and disturbances, nightmare, hallucination, seizures, disturbances in consciousness, paraesthesias and dysaesthesias, peripheral neuropathies, dizziness, writing impaired, vision blurred, photophobia, eye disorders, tinnitus, ischaemic coronary artery disorders, tachycardia, haemorrhage, thromboembolic and ischaemic events, peripheral vascular disorders, vascular hypotensive disorders, dyspnoea, parenchymal lung disorders, pleural effusion, pharyngitis, cough, nasal congestion and inflammations, gastrointestinal inflammatory conditions, gastrointestinal ulceration and perforation, gastrointestinal haemorrhages, stomatitis, ascites, vomiting, gastrointestinal and abdominal pains, constipation, flatulence, bloating and distension, loose stools, hepatic enzymes and function abnormalities, cholestasis and jaundice, hepatocellular damage and hepatitis, cholangitis, pruritus, rash, alopecias, acne, sweating increased, arthralgia, muscle cramps, limb and back pain, renal failure, oliguria, renal tubular necrosis, nephropathy toxic, bladder and urethral symptoms, asthenic conditions, febrile disorders, oedema, blood alkaline phosphatase increased, weight increased, body temperature perception disturbed, primary graft dysfunction. Uncommon (>1/1000 to <1/100): coagulopathies, coagulation and bleeding analyses abnormal, pancytopenia, hypoproteinaemia, hyperphosphataemia, hypoglycaemia, coma, central nervous system haemorrhages and cerebrovascular accidents, paralysis and paresis, encephalopathy, speech and language disorders, amnesia, cataract, arrhythmias, cardiac arrest, heart failures, cardiomyopathies, infarction, deep venous thrombosis, shock, respiratory failures, respiratory tract disorders, asthma, paralytic ileus, peritonitis, acute and chronic pancreatitis, anuria, haemolytic uraemic syndrome, uterine bleeding, psychotic disorder, multi-organ failure Rare (>1/10,000 to <1/1000): thrombotic thrombocytopenic purpura, blindness, neurosensory deafness, pericardial effusion, acute respiratory distress syndrome, subileus, pancreatic pseudocyst, hepatitic artery thrombosis, venoocclusive liver disease, toxic epidermal necrolysis (Lyell's syndrome). Very rare (<1/10,000 including isolated reports): hepatic failure, bile duct stenosis, Stevens Johnson syndrome, nephropathy, cystitis haemorrhagic. Neoplasms. **PRESCRIBERS SHOULD CONSULT THE SUMMARY OF PRODUCT CHARACTERISTICS IN RELATION TO OTHER SIDE EFFECTS.** FOR FULL PRESCRIBING INFORMATION SEE SUMMARY OF PRODUCT CHARACTERISTICS. **Package Quantities, Basic NHS cost & Product licence numbers:** AOVAGRAF®/PRDGRAF®: 0.5 mg capsules x 50 = £42.22 (EU/1/07/387/002)/£65.69 (PL 13424/0004), respectively. 1 mg capsules x 50 = £84 43 (EU/1/07/387/004)/£85.22 (PL 13424/000), respectively 1 mg capsules x 100 £168.87 (EU/1/07/387/006)/£170.43, (PL 13424/0001) respectively. 5 mg capsules x 50 £422.17 (EU/1/07/387/008)/£314.84, (PL 13424/0002), respectively. **Legal Classification:** POM. **Date of Preparation of API:** 19 September 2008. Further information available from Astellas Pharma Ltd, Lovett House, Lovett Road, Staines TW18 3AZ PRDGRAF® is a registered trade mark. **For medical information phone 0800 783 5018**

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Astellas Pharma Ltd - 0800 783 5018

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AST5018108/October 2008/WBR

How to win awards and influence people

C+D 08 AWARD WINNER

Duncan Murray reveals the tactics that bagged his pharmacy group the Retail Service of the Year crown at the C+D Awards 2008. Max Gosney meets the man with the Midas touch

Where did you get the idea for supplying mobility equipment?
"Previously when patients needed a mobility aid we would have to phone the council who would then send someone out to assess the individual. The whole process would end up costing them £30 for a piece of kit worth £5. The council came to us with the idea of supplying the patients direct. I think they saw we already had expertise in selling disability aids and servicing mobility equipment at the Stourbridge pharmacy. I thought it was a great idea. I don't know why we didn't start it years ago."

How does it work?
"The patient comes in and one of our staff carries out an assessment for the equipment. It's generally small items to help someone out around the home like grab rails or easy to use can openers. We supply the product and return the completed paperwork to the council."

How much money do you make?
"It's a bit on top rather than a massive money spinner. I'd say around £500 a month. It's worth doing because it's a service to the community. I think it also highlights our mobility aid business."

What are the advantages of setting up a service like this?
"It's not a service that needs a lot of training because there are not a lot of complex procedures. You don't have to spend a fortune on training your staff. Also, I don't think you need to be a specialist in mobility equipment. Anybody could get involved."

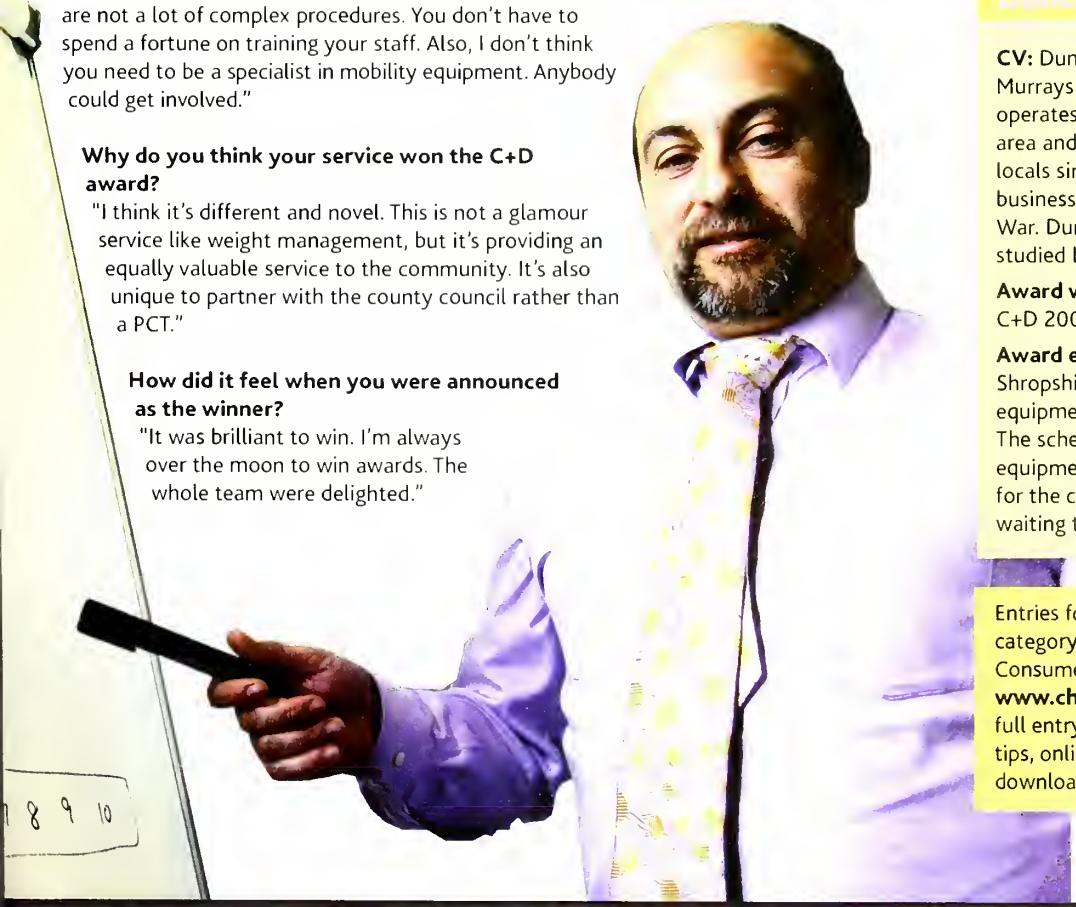
Why do you think your service won the C+D award?
"I think it's different and novel. This is not a glamour service like weight management, but it's providing an equally valuable service to the community. It's also unique to partner with the county council rather than a PCT."

How did it feel when you were announced as the winner?
"It was brilliant to win. I'm always over the moon to win awards. The whole team were delighted."

What advice would you give to someone considering entering next year's C+D awards?
"I'd say find out who won last year and phone them up. Talk to them about what they did and how they did it – then you'll know what impresses the judges."

What tips would you give on setting up services in general?
"Find out what services your PCT or other organisations want. Then you need to decide whether you're willing to invest your time and money into providing them. Some services have higher start up costs than others. Mobility aid supply costs very little to get off the ground. However, we've spent thousands training staff for anti-coagulant testing. Also, I think it's important to involve the whole pharmacy team in training. You need the people on the front line to be able to assist and signpost customers appropriately."

What's the most common mistake made by pharmacies when setting up a new service?
"I think the biggest problem is expectation that's been created within pharmacy. Lots of people put everything in place to provide a service only to find out they're not going to be commissioned by the PCT."



Duncan Murray file

CV: Duncan Murray has been at the helm of Murrays Healthcare since 1991. The group operates 25 pharmacies in the West Midlands area and has been providing healthcare to locals since Cyril Murray founded the first business upon returning from the First World War. Duncan Murray is a non-pharmacist; he studied business instead.

Award won: C+D Retail Service of the Year, C+D 2008

Award entry: Mr Murray teamed up with Shropshire County Council to provide mobility equipment to patients in the Stourbridge area. The scheme allows residents to pick up equipment from the pharmacy rather than wait for the council to deliver. This has cut costs and waiting times.

Entries for the **C+D Retail Service of the Year** category, sponsored by GlaxoSmithKline Consumer Healthcare, are now open. Go to **www.chemistanddruggist.co.uk/awards** for full entry details, hints and tips, online entry or to download an entry form.

C+D AWARDS 09

The best industry event of the year is back and it promises to be even more glamorous and prestigious than before. Championing the very best of community pharmacy, the C+D Awards 2009 celebrates the people and companies who go above and beyond the call of duty when delivering pharmacy services.

Whether you are a newly qualified pharmacist or a pharmacy technician, an LPC chief executive or a pre-reg student, this is your chance to be in the spotlight. Tell us about your achievements and it could be you on the winner's podium.

Last year's event was a glittering occasion, as the winners received their trophies in front of a sell-out crowd at London's Grosvenor House Hotel and partied late into the night. This year there are 15 categories covering every aspect of community pharmacy – so make sure you don't miss the chance to be a C+D Award winner.

Trophies will be presented at an awards ceremony on Wednesday 17 June 2009 at London's Grosvenor House Hotel. Complete your entry now and don't miss the chance to be a winner at the C+D Awards 2009.

Good luck!

Gary Paragpuri, C+D Editor

The award categories

- Community Pharmacist of the Year
- Pre-registration Graduate Pharmacist of the Year
- New Pharmacist of the Year
- Pharmacy Manager of the Year
- Pharmacy Technician of the Year
- Pharmacy Assistant of the Year
- MUR Champion of the Year
- Clinical Service of the Year
- Retail Service of the Year
- Business Development of the Year
- Green Award
- Pharmacy Team of the Year

NEW FOR 2009

- Pharmacy Innovation of the Year
- Pharmacist Prescriber of the Year
- Pharmacy Business Leader of the Year

Full details of all the categories, an entry form and hints and tips can be found on the C+D website at **www.chemistanddruggist.co.uk/awards**

The judges

Carwen Wynne Howells, chief pharmaceutical adviser, Wales
Norman Morrow, chief pharmaceutical officer, Northern Ireland
Keith Ridge, chief pharmaceutical officer, England
Bill Scott, chief pharmaceutical officer, Scotland
Andy Murdock, director of pharmacy, Lloydspharmacy
Alan Nathan, pharmacy writer/consultant
Clive Jackson, chief executive, National Prescribing Centre
Rob Darracott, chief executive, CCA
John D'Arcy, interim managing director, Numark
Steve Dunn, business consultant
Rachel Marchant, senior learning & development manager, Boots
Nicola Griffith, group training & development manager, Co-operative Pharmacy
Marilyn Jones, training manager, Weldricks
Paul Bennett, superintendent pharmacist, Alliance Boots
Nick Barber, professor of pharmacy practice, London School of Pharmacy
John Nuttall, managing director, Co-operative Pharmacy
Jonathan Mason, national clinical director for community pharmacy, Department of Health
Fin McCaul, C+D Pharmacy Team of the Year 2008 Winner
David Smith, C+D MUR Champion of the Year 2008 Winner
Aniket Parikh, C+D New Pharmacist of the Year 2008 Winner
Nichola James, C+D Pharmacy Manager of the Year 2008 Winner
Pamela MacPherson, C+D Pharmacy Technician of the Year 2008 Winner
Amanda Wells, C+D Pharmacy Assistant of the Year 2008 Winner
Ravi Patel, C+D Pre-registration Graduate of the Year 2008 Winner
Stephen Foster, C+D Clinical Service of the Year 2008 Winner
Paul Howie & Dave Roberts, C+D Business Development of the Year 2008 Winner
Duncan Murray, C+D Retail Service of the Year 2008 Winner
David Croucher, C+D Green Award 2008 Winner
Valerie Sillito, C+D Community Pharmacist of the Year 2008 Winner

How to enter

- Full category details plus hints and tips for entry can be found on our website at **www.chemistanddruggist.co.uk/awards**
- Choose which category you wish to enter. There is no limit to the number of categories you can enter. The same entry cannot be used in more than one category. A separate entry form must be completed for each category entered. Current C+D Award winners cannot re-enter the category they won in 2008 but are free to enter any other category in 2009.
- Entries must be submitted using either the awards entry form below, or alternatively, by completing the simple online entry process at www.chemistanddruggist.co.uk/awards.
- Your submission must not exceed 500 words. You must describe what you have done and why you deserve to win. The judges will look to see how you meet the criteria for each category. Full entry details can be found at C+D's website. You should include supporting material (clearly labelled) such as testimonials, financial results, research, performance metrics, photographs, service protocols, press clippings, marketing material etc. These should be provided to enhance your chances of winning. Remember, the more detail you provide, the easier it will be for the judges to make an informed decision. Please note that supporting material does not count towards the 500 word limit. Please submit five copies of your entry form and all support materials.
- Note that entries without appropriate supporting evidence such as applicable financial information will not be shortlisted, as such information forms an essential part of the judging process.
- All entries will be treated in the strictest confidence and will only be used for the purpose of the judging process. Judges sign a confidentiality agreement and sensitive entry information is not published. We are unable to return any supporting material provided; so you may wish to send copies rather than the original documentation. Work referred to in awards entries should have taken place between 1 January 2008 and 31 December 2008. Preparatory work could have taken place earlier than 1 January but only results achieved in 2008 will be taken into account.
- The judges will independently mark entries against the award criteria set out in each category – so make sure you provide all the information requested. The judges' scores will be collated to find the winner. C+D will notify those who have made it to the shortlist and publish details in the magazine. All shortlisted entrants will be invited as C+D's guests to the awards ceremony on Wednesday 17 June 2009 at the Grosvenor House Hotel in London, where the winners will be revealed and presented with their trophies. The winners will also be featured in C+D following the awards evening.

Entry form

Please complete all fields and send this form or a copy with your entry submission to: Katherine Mannix, C+D Awards 2009, Ludgate House, 245 Blackfriars Road, London SE1 9UY by **Friday 6 March 2009**

You can also enter online at www.chemistanddruggist.co.uk/awards

Category entered

Your full name

Job title

Name of pharmacy

Address

Postcode

Daytime telephone no

Mobile no

Email

Yes, I would like to be registered for the C+D Email news bulletins which will keep me up-to-date with all the awards news as and when it happens ❑

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Illustration Gary Swift

Selling healthy sex

Sexually transmitted infections are on the increase, so are there emerging opportunities for community pharmacy? Oh yes, says **Kathy Oxtoby**

Time was when using a pharmacy's sexual health service meant a furtive condom purchase. Then came the sexual revolution. And now there's a quiet revolution going on in community pharmacy where the aim is to improve sexual health. As well as getting involved in sexual health promotion, pharmacies are being commissioned by PCTs to deliver such services as emergency contraception, chlamydia testing and treatment, and condom distribution.

Pharmacies are well placed to overcome the barriers faced by people requiring sexual health services. "Community pharmacy can play a vital role in reaching those who are less likely to access healthcare any other way. Pharmacy can offer a discreet service that will also be cost-effective for the NHS," says Mimi Lau, Numark's director of professional services.

Now, with the pharmacy white paper's proposal that there should be service development in the area of sexual health, there seems to be long-term support for pharmacy to provide this vital community service.

That support is much needed, given the rising number of people with sexually transmitted infections in the UK. The latest figures from the Health Protection Agency (HPA)[1] show there were 397,990 newly diagnosed STIs in clinics last year, up from 375,843 in 2006. Half of everyone diagnosed with an STI in 2007 was aged between 16 and 24.

Age concern

Many pharmacists are choosing to take part in the drive to address the high levels of sexual ill health and pregnancy among youngsters, supporting and signposting them to relevant NHS services. Yogin Patel of Baywood Chemists, London, has been helping to raise awareness about the government's campaign to vaccinate schoolgirls aged nine to 14 against the HPV virus. "Pharmacists are in an ideal position to give out information to parents," he says. Michael Maguire, of F I Maguire, a Numark pharmacy in Middlesbrough, takes part in the C card scheme, ▶

National **Chlamydia Screening** Programme

NHS

Do you know which of these has chlamydia?

The National Chlamydia Screening Programme (NCSP) is a control and prevention programme for young people under the age of 25. This group is at highest risk - one in 10 who are tested have chlamydia.

Chlamydia is often asymptomatic so often remains undiagnosed.

But it is easy to test and to treat. Young people can do the test themselves and no examination is required.

To find out more and to register with your local chlamydia screening office log on to **www.chlamydiascreening.nhs.uk**

Health Protection Agency

Get proactive – offer chlamydia screening

Michael Maguire (above) believes pharmacists should "think creatively to raise awareness among hard to reach groups like the over 45s, for whom sexual health can be a taboo subject"

> "Think creatively to raise awareness among hard to reach groups like the over 45s"

distributing free condoms to teenagers. He has also been commissioned by the PCT to offer chlamydia screening and emergency hormonal contraception. These initiatives, he believes, "have helped to reduce the high prevalence of unwanted pregnancies in the area".

But while sexual health services and campaigns have tended to focus on young people, recent research has highlighted the importance of raising awareness and giving support to the over 25s. In June this year, an HPA study revealed sexually transmitted infections among people over 45 have doubled in under a decade.[2]

Older people are more susceptible to STIs as they are less likely to use condoms than youngsters, the research suggests. It recommends programmes aimed at preventing STIs should be tailored towards different age groups and do more to dispel myths and assumptions about the level of sexual activity among older age groups.

Mr Maguire points out that sexual health initiatives in community pharmacy are led, to some extent, by local needs – for example, the PCT may want to commission services that target teenage pregnancy rates. But he believes pharmacists should "think creatively to raise awareness among hard to reach groups like the over 45s, for whom sexual health can be a taboo subject". For example, by featuring health advice on a plasma screen his pharmacy is able to give information without causing embarrassment.

Lynn Hearton, helpline and information services manager for fpa, formerly the Family Planning Association, stresses that the focus on the sexual health of young people should not be to the detriment of other generations. "We need to send out messages to everyone that if you are sexually active you are also at risk of STIs," she says.

A recent example of how the sector is targeting certain age groups is the NPA's private chlamydia screening service for pharmacies, following the switch of azithromycin from POM to P. Actavis, which manufactures the pharmacy-only medicine version of azithromycin under the brand name Clamelle, is publicising the service, with a £2 million advertising campaign in the first year focused on the over 25s, for whom PCOs do not offer funding. Patients will be charged £25 for the chlamydia test kit, and then £20 for the Clamelle drug if they need treatment. NPA members need to register for the service and pay £21 to obtain a resource pack.

Neal Patel, the NPA's head of communications, says the service "builds on pharmacy's strengths. We already have an association with sexual health – and it increases patient choice".

Judging by the take up – 50 per cent of NPA UK members are now enabled for the screening service prior to the launch of the antibiotic this month – the sector is embracing the chance to offer oral antibiotics over the counter for the first time.

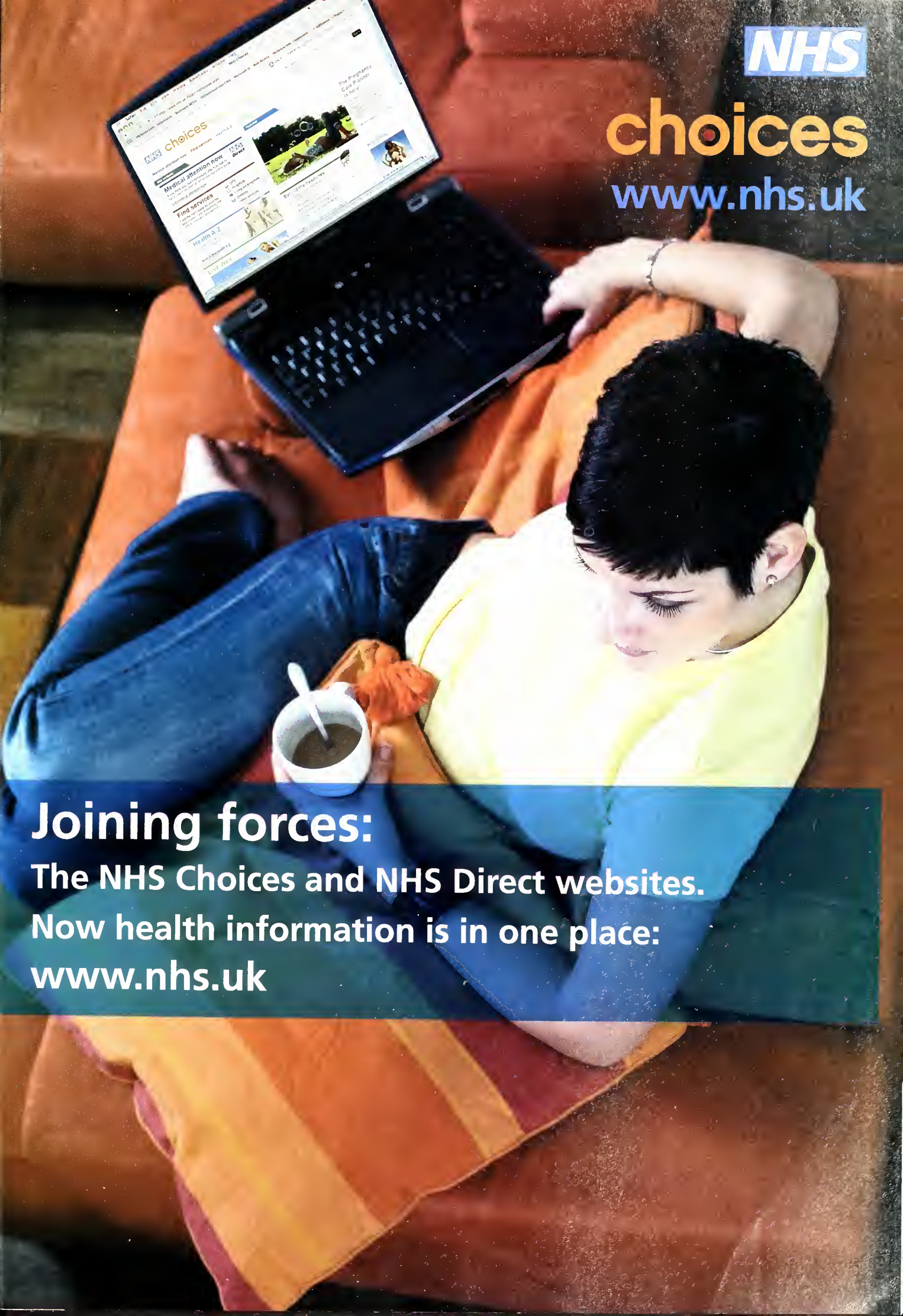
Make sex sell

To help pharmacy move into this new service era, the RPSGB plans to produce guidance on setting up and promoting sexual health services, which is due to be published in the spring of next year.

"As more services develop there are opportunities for pharmacists to get involved and to provide a slightly more clinical service," says Meghna Joshi, senior professional support pharmacist for the Society.

Assessing, screening, control of STIs and looking at how to reduce inequalities around sexual health in communities are just some of the pharmacy services that could evolve over the next few years, she says.

With recent studies revealing one in 10 Brits are too embarrassed to buy condoms[3], and a high proportion of people are not using them when they have sex with a new ▶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Case study – Glyn Ratcliffe

Glyn Ratcliffe of [illegible] Pharmacy, a [illegible] pharmacy in Birmingham, believes sexual health is an area pharmacy is ideally placed to get involved with. "It's not a market you have to create – it's already there. We were already being asked for condoms, selling pregnancy tests and signposting people to sexual health services," he says.

So when the emergency hormonal contraception pill became available as a pharmacy-only product, pharmacy staff trained to provide the service. And when South Birmingham PCT approached the pharmacy to help ensure women received antenatal care earlier on in their pregnancy, it started doing pregnancy tests based on referrals from GPs and Connexions, the young people's advisory service.

"Now as well as signposting services to people, we get people signposted to us," he says.

Pharmacy staff also provide emergency hormonal contraception, offer advice about STIs and there are plans to provide private chlamydia screening and treatment under the new NPA scheme.

In time, Mr Ratcliffe hopes the pharmacy might be a port of call for repeat prescribing of oral contraception, which would increase the ease of access and convenience for patients.

Having staff on board and trained, being proactive and persistent and working with PCTs to identify their priorities will help pharmacists develop their sexual health services, he believes.

"We just need to keep on feeding the message to people that we're here, we're available and people are using us – so they should make the most of us."

Glyn Ratcliffe: hopes the pharmacy will be a port of call for repeat prescribing of oral contraception

> "It's not a market you have to create – it's already there"

partner[4], pharmacy has an opportunity to tackle taboos and promote a positive attitude towards sexual health.

"There's too much focus on the negatives, on infection rates and unwanted pregnancies. Sexual health is also about being well and having fun. It should have a more positive feel, and pharmacists could be part of that," says the fpa's Ms Hearton.

Instead of having condoms tucked away near the plasters, aspirins and other products associated with ailments, she suggests pharmacies could have whole areas devoted to sexual health products and services, taking their lead from the colourful promotional material used by drug companies.

She also suggests liberal signposting of the sexual health services that are available both in and outside the pharmacy. "This tells people that you're knowledgeable about the issues and makes people more confident about approaching their pharmacist for information and advice."

Mr Maguire says staff should attend appropriate sexual health training courses, such as those run by their PCT or by the Centre for Pharmacy Postgraduate Education (CPPE), "so that they feel comfortable giving advice to customers and to help ensure their opinions and principles do not influence their treatment of others".

As well as being proactive about promoting services, pharmacists need to make sure they are delivering what their local communities need. Mr Maguire says it is important to build a working relationship with the PCO to find out what local targets are and to spell out what pharmacy can do to help achieve them.

All the effort will be worthwhile, he believes, not only because of the business benefits but because of the chance to make a genuine difference to the wellbeing of the local community.

"People are so grateful for your advice, particularly the youngsters who may be feeling frightened," he says. "We want these young people to come to us, to get them in the 'healthcare loop' so that they are aware that we, and other healthcare professionals, are there to support them. Then, as they grow older, they will know their pharmacy is the natural place to go for advice and support. And when they have families, their children will know this too."

For further information on the NPA's private chlamydia screening service for pharmacies visit:
[illegible]

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postScript

Open Mike — Mike Hewitson

The not-so-secret diary of a new pharmacy owner

Mike Hewitson is a glutton for punishment. In the midst of economic downturn and with first-time fatherhood looming, Mike has bought his first pharmacy. In this regular column, follow him from his former home in Cheltenham to Beaminster Pharmacy in deepest, darkest Dorset, and Mike will reveal the fears, frustrations and step-by-step successes of a new pharmacy owner.

> "We took the bags to the local recycling centre, and were very relieved to see the back of them"

This week has literally been rubbish! Having forgotten to put the bins out last week, I've been steadily building up a mountain of black bags in the garden. And to make matters worse I have been clearing out both of my stockrooms and have collected a series of weird and wonderful things from an old microfiche machine to a copy of the War Formulary.

Unfortunately, the more mundane rubbish had to go, so we built the Leaning Tower of Black Bags outside the shop on bin day, only for the bin men to refuse to take them. Grrr!

We took the bags to the local recycling centre, and were very relieved to see the back of them. That was... until the tip phoned us to come and collect our rubbish bags before we were fined because they were business waste. Grrrrrr!

Wanting to avoid a telling off at the tip, I managed to grab my bags while none of the attendants was looking. And at 7am this morning I found myself filling a skip with 30 bin bags and assorted junk.

Oooh, the glamorous world of small business!

Follow Mike online at www.chemistanddruggist.co.uk/openmike

Society to the rescue?

The RPSGB has been doing good all round this week. First they teamed up their RX Factor winner Hannah Stretton with former England cricketer Phil "Tuffers" Tufnell (pictured) to promote the Society's men's health campaign. The campaign encourages men to look after themselves and visit pharmacies for advice.

But, perhaps most importantly, the Society claims to have solved that most distressing of questions: what should you buy the pharmacist in your life for Christmas?

Their suggestions, all available from the Society's museum, include "hand-finished replica jars", books on pharmacy history and "stocking fillers" such as a DVD showing demonstrations of historical dispensing equipment, and a CD of images from the museum's collections.

Form an orderly queue...

Web comment of the week

Health minister: dispensing doctors will not derail white paper reforms Posted by David Baker on 14/11/2008, 13:26

> I agree with **Ben Bradshaw** that our justifiable concerns should not overshadow the other important provisions in the white paper. We have no argument with **pharmacy** or **pharmacists**

Have your say on C+D's website
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Wakey, wakey

Good to see that the government in Northern Ireland is as engaged with the world of pharmacy as the rest of the UK.

This week C+D made an enquiry to the Department of Health, Social Services and Public Safety on the withdrawal of drug manufacturer Actavis from the NI generic medicines tendering process. The response from the press office? "What's Actavis?"

And at the PSNC conference, delegates received a booklet containing copies of speakers' PowerPoint presentations. This is all well and good, but the last two slides from one unfortunate presenter read: "Customer feedback: Penny would like to include some anecdotal info from the audit. Do we have any?" Whoops! You can't beat a good proofreader.

What have you and your team been up to lately?
Let us know and send us your photos.
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Springboard

Springboard Pre-registration Training Programme

The **Medway School of Pharmacy**, in partnership with **C+D**, is launching **Springboard**, an exciting new pre-registration training programme. **Springboard** will cover all aspects of the community pharmacy experience and assist the trainee in making a smooth transition from student to professional.

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The programme will enable the student to meet the appropriate competences in the RPSGB pre-registration student handbook, and will offer support to pre-reg tutors. There will also be a tutor training day. Students will have access to a member of staff at the university and the university's facilities.

This programme is unique in that the students will have the opportunity to be accredited to provide medicines use reviews. Additionally students will be able to accumulate credits by completing distance learning courses included in the programme that can be put towards a postgraduate qualification.

All eight student study days and the tutor day will be held at Medway School of Pharmacy in Kent.

For more information on the **Springboard** course, complete the slip below and return to:
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